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The Journal  
OF THE  
British Homoeopathic Society

*NEW SERIES*

**VOL. XIII.**

**SESSION 1904-1905**

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**GILES F. GOLDSBROUGH, M.D.**

**London**

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—  
1905

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## **NOTICE.**

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**THIS volume comprises the Proceedings of the BRITISH HOMŒOPATHIC SOCIETY during its Sixtieth Session, 1904-1905.**

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*Founded 1844.*

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1890 ALEXANDER, SAMUEL PHILIP, M.D., C.M.Glas., M.R.C.S. Eng.; Tecumseh House, 20, Kent Road, Southsea.

1893 ARNOLD, FRANCIS SORELL, B.A., M.B., B.Ch.Oxon., M.R.C.S. Eng., L.S.A.; Hailey Sanatorium, Ipsden, Wallingford.

1899 ‡ASHTON, JAMES THORNHILL, M.B., C.M.Edin.; Medical Officer, Electro-therapeutic and X-ray Department, London Homœopathic Hospital; 5A, New Burlington Street, W., and 13, Onslow Crescent, S.W.

1902 ‡AVENT, ARTHUR, L.R.C.P., L.R.C.S.Ed., L.F.P.S.Glas., L.S.A.Lond.; Hon. Surgeon to the Birmingham and Midland Homœopathic Hospital and Dispensary; The Towers, Hamstead Road, Handsworth, Birmingham.

1894 BARRETT, JOHN JAMES, M.D.St. And., L.R.C.P.Lond., M.R.C.S.Eng.; 170, Ramsden Road, Balham, S.W.

1891 BARROW, ROGER WILLIAM, M.D.Brux., L.R.C.P., L.M. Edin., M.R.C.S.Eng. (*Address not communicated.*)



## Elected

- 1899 BEALE, ARTHUR ARNOLD, M.B., C.M.Glas.; Assistant Surgeon and Anæsthetist to the London Homœopathic Hospital; 32, Weymouth Street, W., and 4, Acacia Road, St. John's Wood, N.W.
- 1868 BELCHER, HENRY, M.D.Univ.Erlang., L.R.C.P.Edin., M.R.C.S.Eng.; Fell. Obst. Soc., Lond.; Honorary Treasurer to the Sussex County Homœopathic Dispensary; 28, Cromwell Road, West Brighton.
- 1890 BENNETT, HENRY, L.R.C.P., L.R.C.S., L.M.Edin., L.A.H. L.M.Dub.; 323, Holloway Road, N.
- 1892 BIRD, ASHLEY, M.R.C.S.Eng., L.S.A.; Culverlands, 33, Stamwell Road, Penarth, Glamorganshire.
- 1894 BLACK, GEORGE, M.B., C.M.Edin.; Greta Bank, Torquay.
- 1872 \*BLACKLEY, JOHN GALLEY (*Treasurer*), M.B.Lond., M.R.C.S. Eng.; Senior Physician and Physician for Diseases of the Skin to the London Homœopathic Hospital; 29, Devonshire Place, W. (P. 1892. V.-P. 1884, 1891. S. 1885-1891. T. 1892-1904)
- 1901 BLAIR, JAMES ANDREW, M.D., C.M.Edin., D.Sc. (Public Health), L.R.C.P.Lond.; 16, Windsor Terrace, Newcastle-on-Tyne.
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- 1896 BODMAN, JOHN HERVEY, M.D., B.S.Lond., M.R.C.S.Eng., L.R.C.P.Lond.; Physician to the Hahnemann Hospital, Bristol; 3, White Ladies Road, Clifton, and 7, Wine Street, Bristol.

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the Leicester Homœopathic Hospital; 29, Seymour  
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C. 1892.)
- 1872 ‡BRYCE, WILLIAM, M.D.Edin.; 34, Greenhill Gardens, Edin-  
burgh.
- 1889 \*BURFORD, GEORGE (*Council*), M.B., C.M.Aberd.; Physician  
for Diseases of Women to the London Homœopathic  
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mouth; to the Phillips Memorial Hospital, Bromley;  
to the Lansdown Homœopathic Hospital, Bath; to  
the Homœopathic Cottage Hospital, Leicester; and to  
the Hahnemann Hospital, Bristol. 35, Queen Anne  
Street, W. (P. 1901. V.-P. 1898-1900. C. 1892,  
1895-7, 1900, 1902-03-04.)
- 1873 BURWOOD, THOMAS WESLEY, L.R.C.P., L.M.I., L.R.C.P.,  
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sex Homœopathic Dispensary; Strathmore, Florence  
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- 1890 CAPPER, EDMUND, M.D., C.M.Edin., Medical Officer to the  
Leicester Homœopathic Cottage Hospital and Dis-  
pensary; 71, Evington Road, Leicester.
- 1891 ‡†CAPPER, PERCY, M.B., C.M.Edin.; Physician to the Hastings  
and St. Leonards Homœopathic Dispensary; Rocklands,  
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Road, Bexhill-on-Sea.
- 1879 \*CASH, ALFRED MIDGLEY, M.D., C.M.Edin., M.R.C.S.Eng.,  
Physician to the Torquay Homœopathic Dispensary;  
Limefield, Falkland Road, Torquay.
- 1892 CAVENAGH, JOHN PAUL, L.R.C.P., L.R.C.S., L.M.I.; Thorne-  
loe House, Worcester.

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- 1873 †CHALMERS, ANDREW CRICHTON, M.D., L.R.C.S.Edin.;  
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- 1891††COOK, HENRY WILLIAM JAMES, M.B., B.S.Durh.; 88, Collins  
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- 1903 †COOPER, ROBERT MONTAGU LE HUNTE, M.D., B.S.Durh.,  
M.R.C.S., L.R.C.P.Lond.; 18, Wimpole Street, W., and  
17, Stanley Gardens, Kensington Park, W.
- 1893 CORBETT, HERBERT HENRY, M.R.C.S.Eng.; 9, Priory  
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- 1892 COX, RICHARD PERCY, M.D., C.M.Edin.; Gwynant, Withing-  
ton, and 80, Deansgate Arcade, Manchester.

Elected

- 1890 ‡COX, WILLIAM SPENCER, M.D.Brux., M.R.C.S.Eng., L.S.A.; Assistant Physician to the London Homœopathic Hospital; Physician to the Kensington, Notting Hill and Bayswater Homœopathic Dispensary; 12, Sheffield Gardens, Kensington, W.
- 1892 ‡CRAIG, JOHN, L.R.C.P.Edin., L.F.P.S.Glas.; Shelton House, Stoke-upon-Trent.
- 1862 CRONIN, EUGENE FRANCIS, M.D.St. And., M.R.C.S.Eng., L.S.A.; Old Manor House, Clapham Common, S.W.
- 1892 CROUCHER, ALEXANDER HENRY, M.D., C.M.Edin., F.R.C.S. Edin.; Physician and Surgeon to the Leaf Homœopathic Cottage Hospital; to the Eastbourne Homœopathic Dispensary; and to the Eastbourne Homœopathic Convalescent Home; Onslow House, 6, Burlington Place, Eastbourne.
- 1867 ‡CROUCHER, ALEXANDER RICHARD, M.D.St. And., M.R.C.S. Eng., L.S.A., L.M.; Consulting Physician to the Buchanan Hospital, St. Leonards-on-Sea; 26, Portland Terrace, Southampton.
- 1899 ‡DAWSON, HARRY GEORGE FREDERICK, L.R.C.P.I., L.R.C.S.I., L.M.; 23, Hamilton Square, Birkenhead, and 35, Beresford Road, Oxton, Cheshire.
- 1887 \*DAY, JOHN ROBERSON, M.D.Lond., M.R.C.S.Eng., L.R.C.P. Lond., L.S.A.; Physician for Diseases of Children, and Consulting Anæsthetist to the London Homœopathic Hospital; 35, Queen Anne Street, W., and 50, Belsize Park, Hampstead, N.W. (P. 1902. V.-P. 1900-1. C. 1896)
- 1892 \*DEANE, HERBERT EDWARD, M.R.C.S.Eng., L.S.A.; Lt.-Colonel, Royal Army Medical Corps (*Retired*); Assistant Physician to the London Homœopathic Hospital, 33, Weymouth Street, W.
- 1875††DECK, JOHN FIELD, M.D.St. And., M.R.C.S.Eng., L.R.C.P. Lond.; Ashfield, Sydney, New South Wales.
- 1893 EATON, HENRY ARNOLD, M.B., C.M.Edin.; 16, Eldon Square, Newcastle-on-Tyne.

## Elected

- 1887 ELLIS, JOHN WILLIAM (*Vice-President, Liverpool Branch*), M.B., Ch.B.Vict. and Liv., L.R.C.P., L.R.C.S.Edin.; Honorary Physician to the Hahnemann Hospital, Liverpool; 18, Rodney Street, Liverpool.
- 1900 ELLWOOD, THOMAS ASHCROFT, M.R.C.S.Eng., L.R.C.P.Lond., D.P.H.Camb.; 99, Tollington Park, N.
- 1875 \*EPPS, WASHINGTON, L.R.C.P.Edin., M.R.C.S.Eng.; Physician to the London Homœopathic Hospital; 55, Queen Anne Street, W. (P. 1899. V.-P. 1896-98. C. 1893-94-97, 1903, 1904.)
- 1904 †FALLON, ROBERT HUME, M.D., C.M.Aberd.; 1, Thistle Villas, Green Point, Cape Town.
- 1892 FINLAY, JOHN THOMAS, L.R.C.P., L.R.C.S., L.M.Edin., L.A.H., L.M.Dub.; Greystone House, Rawtenstall, Lancashire.
- 1881 GILBERT, SYDNEY, L.R.C.P., L.R.C.S.Edin., L.A.H., L.M. Edin. and Dub.; Somersfield Cottage, Reigate.
- 1893 †GILES, FREDERICK WILLIAM, M.B.Durh., M.R.C.S.Eng. (*Address not communicated.*)
- 1881 \*GOLDSBROUGH, GILES FORWARD (*Editor*), M.D., C.M. Aberd.; Assistant Physician and Physician for Diseases of the Nervous System to the London Homœopathic Hospital; 82, Wimpole Street, W., and Churchside, Herne Hill, S.E. (P. 1895. V.-P. 1893-94. C. 1897-98, 1901.)
- 1892 GORDON, JOHN NEWLANDS, M.B., C.M.Aberd.; 70, Upper Parliament Street, Liverpool.
- 1886 GOULD, EDWARD GARDINER, L.R.C.P.I.; Craigmore, Polworth Road, Streatham Common, S.W.
- 1901 GRACE, NATHANIEL, M.D., C.M., McGill Univ., Montreal, M.R.C.S.Eng., L.R.C.P.Lond.; Hon. Surgeon to the Tunbridge Wells Homœopathic Hospital and Dispensary; 2, Calverley Mount, Tunbridge Wells.

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- 1892 \*GREEN, CONRAD THEODORE, M.R.C.S.Eng., L.R.C.P.Lond.; F.L.S.; Fell. Roy. Instit. Public Health; Honorary Medical Officer to the Wirral Homœopathic Dispensary; Capt. Army Med. Reserve; Surg.-Capt. 1st V. B. Cheshire Regt.; 31, Shrewsbury Road, Birkenhead. (P. *Liverpool Branch*, 1896. V.-P. 1899.)
- 1892 \*GREEN, VINCENT, M.D.Edin.; Assistant Surgeon for Diseases of the Throat and Ear to the London Homœopathic Hospital; Physician to the Wimbledon and Merton Homœopathic Dispensary; Greyroofs, Wimbledon Hill, and 155, Fenchurch Street, E.C.
- 1902 GREIG, CHARLES JOHN, L.R.C.P.Edin., L.R.C.S.Edin., L.F.P.S.Glasg.; Physician to the Ealing and West Middlesex Homœopathic Dispensary; Gordon House, 86, Gordon Road, Ealing, W.
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- 1876 HALL, EDGAR ATHELING, M.B., C.M.Edin.; Physician to the Surbiton, Kingston, and Norbiton Homœopathic Dispensary; Seacombe, Adelaide Road, Surbiton.
- 1892 HALL, FREDERICK, L.R.C.P., L.R.C.S.I., L.M.; 18, Shakespeare Street, Nottingham.
- 1894 HARDY, JAMES EBENEZER, M.B., C.M.Edin.; 2, Queen's Crescent, Glasgow, W.
- 1859 †HARPER, JAMES PEDDIE, M.D.Edin., L.R.C.S.Edin.; 43, Hertford Street, Mayfair, W.
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- 1900 HARRIS, LILLIAN MAUDE CUNARD, L.R.C.P.I., and L.R.C.S.I.; 12, Buckingham Place, Brighton, and 4, Palmerston Terrace, Crescent Road, Worthing.
- 1878 \*HAWKES, ALFRED EDWARD (*Liverpool Branch Representative*), M.D.Bru.x., L.R.C.P., L.M., L.R.C.S.Edin.; Medical Officer to the Hahnemann Hospital, Liverpool; 22, Abercromby Square, Liverpool. (V.-P. 1903. P. *Liverpool Branch*, 1892, 1901. V.-P. 1893, 1903-4. C. 1898, 1900-04.)

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- 1892 HAYWARD, CHARLES WILLIAMS (Barrister-at-Law), M.D.,  
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- 1892 HAYWARD, JOHN DAVEY, M.D.Lond., M.R.C.S.Eng., L.S.A.;  
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- 1868 \*HAYWARD, JOHN WILLIAMS, M.D.St. And., M.R.C.S.Eng.,  
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- 1877 MOORE, JOHN MURRAY, M.D., C.M., L.M.Edin., M.R.C.S. Eng., M.D.New Zealand, F.R.G.S. ; Honorary Medical Officer to the Hahnemann Hospital, Liverpool ; Honorary Physician Seaman's Friend Society ; 51, Canning Street, Liverpool.
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- 1904 NEATBY, THOMAS MILLER, M.A.Cantab., M.A.Lond., M.R.C.S.Eng., L.R.C.P.Lond.; Assistant Physician to the London Homœopathic Hospital; 25, Petherton Road, Highbury New Park, N.
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- 1902 POWELL, JOSIAH CECIL, M.R.C.S.Eng., L.R.C.P.Lond. ; 192, Oakhill, Stoke-on-Trent.
- 1898 PRITCHARD, JOSEPH JAMES GAWLER, L.R.C.P.Lond., M.R.C.S.Eng. ; Heathfield, West Park Street, Dewsbury.
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- 1898 PRITCHARD, WILLIAM CLOWES, B.A., M.R.C.S., L.R.C.P. ; Surgeon to the Buchanan Hospital, St. Leonards-on-Sea ; Ophthalmic Surgeon to the Hastings and St. Leonards Homœopathic Dispensary ; 29, Wellington Square, Hastings.
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- 1895 REID, ARTHUR LESTOCK, M.R.C.S.Eng., L.R.C.P.Lond.; Thornborough House, Clarendon Road, Watford. (C. 1900-1.)
- 1872††REID, LESTOCK HOLLAND, M.R.C.S.Eng., L.R.C.P.Lond.; Bowmanville, Ontario, Canada.
- 1894 RENDALL, JOHN MURLY, L.R.C.P., L.R.C.S.Edin.; L.F.P. & S.Glas.; 13, Stafford Street, Edinburgh.
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OUR POSITION AND RELATION TOWARDS  
ORTHODOX MEDICAL PRACTICE.<sup>1</sup>

BY THOMAS SIMPSON, M.D.ST. AND., M.R.C.S.ENG.

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GENTLEMEN,—Since you have gracefully conceded to me the privilege of acting as President of the Liverpool Branch of the British Homœopathic Society I have very seriously considered how I might most profitably improve this occasion ; the cordiality of your invitation overcomes any doubts I might well entertain of being able to bring you any thought worthy of your attention. For forty-seven years, earnest, willing workers have prepared valuable papers for this Society, infinite in variety, but each instructive and memorable. One generation passeth ; we wonder what the next will bring. Our most sanguine expectations cannot be blighted by a candid examination of the causes which have contributed to the tardy progress of our art in Britain during recent years. With resources well-nigh boundless, with armaments of ever-

<sup>1</sup>The Presidential Address delivered before the Liverpool Branch, October 13, 1904.

increasing value and numbers, with illustrious authors who have enriched us beyond all we could have anticipated, most solemn are the responsibilities imposed on us to labour on, to endure all things for truth's sake, and to exercise forbearance towards those who fail to see eye to eye with us.

The learned and the studious of thought have no monopoly of wisdom ; their violence of direction in *some* degree disqualifies them to think truly. We *may* owe many valuable observations to people who are not very acute or profound. The average man lives, and must live, so wholly in convention, that gunpowder charges of truth are more apt to discompose than to invigorate his creed. Either he cries out upon blasphemy and indecency (and crouches the closer around that little idol of part-truth and part-convenience which is the contemporary deity), or he is convinced by what is new, forgets what is old, and becomes ("soi-disant") blasphemous and indecent himself. New truth is only wanted to expand (not to destroy) our civil, and often elegant, conventions. For to do anything *because others* do it, and *not* because the thing is good, or honest in its own right, is to resign all moral control and moral dignity, and go post-haste to the lower latitudes with the greater number. There is a certain class (professors of that low morality so much more distressing than the better sort of vice) to whom you must never represent that what was virtuous in itself was attended by any consequences but good fortune and popular applause. The soul asks *honour* and *not* fame, to be *upright*, not to be *successful*, to be *magnanimous*, not *prosperous*, to be essentially, not outwardly, manly. The casuistry which is displayed by indolent and bigoted partisans of antiquated methods is too subtle for words to express. In the terse language of Locke: "He whose assertion goes beyond his evidence, owes this excess of his adherence only to prejudice ; it is not evidence he seeks, but the quiet enjoyment of the theory and opinion he is fond of, with a formal condemnation of all that may stand in opposition to it, unheard and unexamined." A mind untrammelled by conventionalities always works slowly. Least of all does prejudice enter the mind of a

physician with impunity ; he should ever be ready to grasp new facts, and assimilate or reject them according to their value or their inutility, as one of our own number recently affirmed : " Medical reform is not an engagement in polemical warfare with the general body of the profession who regard us as heretics, but (in spite of misrepresentation, misunderstanding and opposition) a promotion continuously and unremittingly of the advance of a knowledge of homœopathy, and an endeavour to modify practice in accordance therewith." We only allow " the doctrine " to dominate our practice just so far as it becomes verified by fact, and no farther. A good instance of the comparative fruitfulness of such a course is seen in the action of rhus on the skin. In the *London Medical Journal* of August 18, 1874, Dr. Sidney Ringer cites from a *New York Medical Record* some observations on the power of rhus tox. and rhus ven. to inflame the skin. The *facts* are recorded, but *there* they remain absolutely barren ; to us, on the contrary (who use the method of Hahnemann), they have long ago suggested the use of rhus in *such cutaneous affections*, and with the distinguished success which we can claim. The system of medicine which can utilise all pathogenetic facts must commend it to the serious study of every ingenuous and conscientious physician. It is time that the leaders of thought in medicine should renounce the opposition and animadversions in which they persistently indulge, and adopt an attitude of enquiry and earnest search for clinical confirmation of received opinions and reason so far developed. In the minds of those who are convinced of the value of the law of similars in the treatment of disease its scientific truth remains as a conviction, a belief, a faith. We must formulate the basis of this consideration in philosophic relationship with other departments of medical knowledge. Physiologists and pathologists who are at the same time practitioners of medicine ought not to close their eyes to the evidence, or facts of experience, nor to the claims of a method which results from those facts, even though no explanation be forthcoming, and the facts run counter to received

opinions. And it behoves those who have become convinced of the truth of homœopathic law to extend the knowledge gained by experience, by urging their claims upon the sagacity and honesty of their *confrères* in a lucid and logical manner in accordance with recent conclusions in collateral sciences. We are systematists, but we lay claim to be rational physicians, and, above all, practical men. If the homœopathic law is a true guide to finding the curative action of the drug, we desire to follow it as far as is possible, or applicable, and we exclude no other method of cure; being only exclusive in the sense of preferring the method of Hahnemann, which has proved to be the best we know, and therefore exclusive only of everything which runs counter to it. We admit and adopt all that pathology and semeiotics can teach us, as essential to our successful practice. Our principles are not antagonistic to medicine considered as a scientific whole; on the contrary, they constitute a necessary completion of this science, inasmuch as they establish one part of medicine which had hitherto been abandoned to the crudest empiricism, upon a scientific basis. Accordingly, they share with the ancient science of medicine all the suppositions necessary to a knowledge of pathological changes, and are distinguished only from that science by the mode in which they lead to a knowledge of the remedial agent, and bring this in accord with the curative object on two fundamental principles, *i.e.*, the principle of *proving* drugs on the healthy organism; and the therapeutic law, *similia similibus curantur*.

Casting a retrospective glance at the beginning of medicine, we perceive that the early physicians obtained their knowledge of drugs from the people to whom they were administered for various ailments; and accidental experience revealed some of their virtues; by partaking of a plant or fruit indiscreetly, vomiting or diarrhœa was caused. The same substance was afterwards employed for the purpose of exciting similar evacuations; in performing such experiments, it was accidentally found that certain other affections, for which the drug had not been given, disappeared simultaneously, for which reason the same medicine was after-

wards employed for these collateral symptoms on those incidental issues. A series of facts was collected which was utilised as a fountain head of therapeutics. How imperfect and unreliable must knowledge so obtained ever prove to those who ply the healing art is all too patent to the shrewd observer.

Now according to Dr. Drysdale's contention, it is the essential feature of homœopathy (practically originated by Hahnemann, and since his day the exclusive property of our school) to investigate the physiological properties of drugs, and from knowledge thus acquired to formulate certain axioms and laws to which we have confessed allegiance; indeed, *this* is the ground of our faith, affording us a distinct principle and making the results directly applicable to therapeutics. The experiments are the essential means of obtaining the data necessary to carry out the principle. From whatever source, all knowledge of the action of the drugs on the healthy body is precious to *us*, and it has been the special province of pioneers and enthusiasts in our cause to be first in the field to incorporate into our *materia medica* the material which they have so carefully accumulated. We cherish the belief that if we had a more complete repertory to the complete *materia medica* (wherein the methods of working out cases were properly pursued) little more would be needed to convert the whole medical profession.

If we wish to grow we must provide for our younger brethren a fit environment for their continuous acquisition of the knowledge of the action of the drugs on the human subject in a state of health (a method now, happily, budding with promise, and actually adopted by orthodox physicians in this and other lands). They would then apprehend the immense possibilities which the law of similars opens up to them, and, by patient enquiry and careful experiment, prove the truth of our theory and the success which attends its adoption. The most urgent need of our school is more disciples; upon *consistent* men depends the future of our cause. Every facility must be offered to them to acquire an accurate knowledge of our methods of practice and the

grounds of our faith, hence the stern necessity of our being thorough in our allegiance to what we profess, and strict in our conformity with the one law and the exclusive method. By slow processes men are discovering and acknowledging that polypharmacy is obsolete and that a more excellent and reliable rule of prescribing is essential. We must, above all things, *practise* what we profess, cleave to our principles with persistent tenacity, and let all men know under wath banner we sail. We must adopt a firm but conciliatory policy towards our opponents, who will thereby entertain a higher opinion of our integrity than would have been secured by any temporising policy. But persistence is needed, as well as consistency; when we have chosen our part it behoves us to abide by it. A simple, manly character never need apologise for adopting and cleaving to what commends itself to clear judgment and calm, logical reasoning. The unremitting retention of simple and high sentiments in obscure duties is hardening the character to that temper which will work with honour and confidence in the face of fierce opposition and contumely.

The medical profession has within its ranks craven spirits as well as moral cowards, who refuse to enquire into new truths, lest it should not pay to do so. A man may be afraid to offend his seniors and *confrères*, and recoil from the ridicule which awaits him should he dare to transgress the rules of etiquette, rather than subject a suffering mortal to needless misery. A foolish consistency is the hobgoblin of little minds adored by little philosophers and divines. To be great is to be misunderstood ofttimes.

The fear of persecution cuts off a large source of converts, for it is notorious that while teachers and professors in medical schools are eager to impart the knowledge of modern methods of prescribing suggested by the rival firms of enterprising druggists, with which we are daily confronted, they decry the assumption that homœopathy has any priority of claim for the introduction of the very drugs which we have used for years, and now for the first time incorporated into the text-books in use with students of medicine. Instances might be cited too numerous to narrate of the adoption of



such agents as *pulsatilla*, *nux. v.* *euonymin*, *iridin*, *viburnum*, *liq. hydrarg. perchlor.* Leading men keep an ominous silence as to the sources from whence the knowledge recorded is gained, reviling as quacks those who have the honesty to confess the source from which their rivals unblushingly plagiarise. It is impossible to terminate the divisions in the ranks of medicine, but here, as in other spheres of labour for mankind, we are inspired with the firm conviction that a patient continuance in a consistent and intelligent adherence to principle will silence opposition and secure for us ultimately a respectful hearing and a graceful reception. The longer I live the more certain I am of the triumph of truth, if only its advocates shun every obsequious and unworthy expedient. What we need *now* was *always* an essential factor to secure public recognition, even the courage of our convictions, and confidence of ultimate triumphs, bold and lucid thinking, fearless and uncompromising expression, much prudence, with a firm will; every step we take upon our road is a step that brings us nearer the goal; and every obstacle, even though it be insurmountable, can only retard, and never can defeat the final triumph of truth over error. It is, indeed, a happy thought and a glorious inspiration to contemplate the slow but sure progress of mental emancipation that has been in progress during the past century. As representatives of a great and learned profession we desire in every legitimate way to encourage the spirit of research. To discover the *rationale* of medical progress is the ambition of this age; there is an activity about, a yearning desire to adopt a more rational and scientific method of prescribing. Eagerness passes into suspense to know the safest, speediest road to recovery from morbid states, and in the search many new remedies (but familiar to *us* as old friends with new faces) are openly prescribed for the very states of disease in which we have found them well-nigh specific. The extraordinary demand and the great popularity of such drugs as *pulsatilla* and *caulophyllin*, *gelsem.*, *hamamelis*, *podoph.*, *leptan.*, &c., proves the urgent yearning that has existed for some speedy, safe and successful system of therapeutics than has hitherto prevailed. We may safely trust to our position as

medical reformers to finally overcome the hostility of an unscrupulous and overwhelming majority who now revile as quacks those who have the honesty to confess the source from whence the regulars plagiarise. In this country and throughout Europe we are undergoing a steady process of absorption into ordinary medicine. For whenever a physician accomplishes a really good cure it is because he has given a more or less homœopathic remedy. It is astonishing how many pegs there are on which therapeutic ideas may be hung. Paracelsus, Hahnemann, Rademacher, Fletcher, Grauvogl, Virchow, Shussler, all contribute to the store we draw upon. In time and place each method of treatment advocated has its merits. Though we contend for consistency we discourage exclusiveness, and when a physician knows how to apply the sciences collateral to medicine, in the ordinary sense he is better provided with weapons against disease than any other practitioner who only wields one. Yet with all these advantages, in how many conflicts against disease does he not sometimes feel powerless before a phalanx of symptoms which he can neither alleviate nor subdue? Surely our main object in life must be to employ our individual talent for the increase of good in the world; this modest ideal is sufficient for us, and it preserves us from the small and narrow mind, the unsympathetic heart, and prompts us to preserve an open mind for every new truth. The public have loftier ideals of the sacredness of the physician's calling than to imagine that he would deprive a sufferer from the relief which any known expedient might secure, even though it does not wear the superscription of orthodoxy upon its passport. With the expectation probably of propping up a tottering bigotry, a word redolent of intolerance has been borrowed from the ecclesiastical vocabulary and applied to the art of curing disease. We hear of orthodox medicine. Surely the promulgators of this phrase are incapable of seeing the ludicrous position in which they place themselves and the profession by the application of such a word to medicinal treatment in the human body, with its endless temperaments, constitutions and variations of morbid phenomena.

The growing intelligence of the race must one day protest against any monopoly of wisdom being the sole possession of legally licensed men who elect to constitute the only legitimate healers of disease.

The timely appearance of Dr. Dyce Brown's lucid and trenchant criticism on the current trend of medical thought will accomplish untold good to the cause of truth and right, and each of us can exert a permeating influence by the eloquence of reason, which is always more potent than the eloquence of passion, for naked and unadorned, this is an instant and immediate force. It is easy to see that there is no limit to the chapter of resources, and our attitude is always one of docility and candour, so that we have gained a reputation for ingenuousness for which we are proud. Hope never spreads her wings but on unfathomable seas, and if ever there was a time when aspiration after increase of knowledge was manifest it is in our own, and the science and art of medicine have become more fully appreciated by the general public than ever, and though we appear to have lost what we had wrought, we have gained the greater and more enduring position of being the pioneers of rational medicine in this land, and the harvest which must one day be secured will make for the uplifting and improved health of this mighty Empire.

Gentlemen, I thank you for according to these disjointed and fragmentary remarks so patient a hearing. May what I have said be received, as it has been written, with calmness, benevolence, and pure love of truth, without party spirit or any resenting of what appears to be dictatorial. May it contribute to bring about mutual understanding and union, for it must be obvious that mutual forbearance and voluntary service in our ranks are sorely needed. We should never allow the outsider to suspect the presence of jealous or envious sentiments in our minds, not being opposed to one another as enemies, but extending to each honest, upright *confrère* the hand of friendship, united by one noble idea, one common object, and by the same general principle of reason and experience founded on pathology and therapeutics. Let us ever go forward to the attainment of—"the

physical welfare of the human race." Our object is not mere sectarianism and self-aggrandisement, but the elucidation and the promulgation of *truth*. Every honest and intelligent practitioner knows that there are remedies of unquestionable value, the action of which could never have been discovered by any such dogmas as *contraria contrariis curantur*; for the more intimately we become acquainted with the occult properties of drugs and their physiological action the more plainly do we see that all explanation of their action is involved in deepest mystery. So that we are not always able to explain even to ourselves the subtle workings of remedial agents on the human subject, though we claim the privilege and prerogative "to utilise every therapeutic agent, medicinal, regiminal, dietetic, balneological, or electrical."

Perhaps I shall best express my' views by remarking on the most successful way to secure the marvellous results of homeopathic treatment. This is, in my humble opinion, that of individualisation and patiently waiting the action of remedies, carefully chosen, in strict accordance with the directions given by the master and author of our school, *e.g.*, in the following order: (1) The mental or moral, or head symptoms; (2) the most peculiar or uncommon symptoms; (3) the latest symptoms. The most severe symptoms, the past symptoms, are valuable in deciding the remedy when in doubt, or as confirming the choice we make.

Mental symptoms are of more value than bodily signs, but if the bodily symptoms are very peculiar or urgent, and the mental are not so, the indications are reversed. The above order gives the keynote in working out a case, but *ceteris paribus* must always be understood. Thus, an ordinary angina, treated by the ordinary remedies, bell., merc., lyc., resisted our efforts to cure, but on observing that the patient *wept* when replying to a question, *pulsat.* suggested itself, with results highly satisfactory; so also in constipation, with sleepiness, depression, *lyc.* would suggest itself; and when restlessness with fear of death co-exist we promptly prescribe *ars.* for prostrate states, and *acon.* in acute febrile conditions. We shall be reminded of aurum

if suicidal tendencies are present in tertiary syphilis, and of anacardium in any case when the memory fails. When a patient loses his way in familiar streets and is otherwise forgetful, *glonoine* relieves, and so on. Through the long array of peculiar mental states accompanying morbid conditions we possess guiding symptoms of great value when selecting the drug indicated in any given case. The most peculiar symptom will often lead to a choice which at first sight seemed remote from our minds, *thus* chamomilla lately relieved a group of symptoms occurring during an attack of rheumatic arthritis, with violent, insupportable pains, profuse sweat of covered parts, impatience, with sleeplessness. If the diarrhoea of infants is attended with vomiting of milk with great force suddenly, and a soporous state, *æthusa* acts well; here we find that the most *peculiar* coincides with the most *severe* symptom, and guides our choice of the drug. A complete repertory is essential to the speedy discovery of the right medicine, and in the cypher repertory differentiation is easy and speedy. It seems to us that greater success and more pleasure would attend our daily prescribing if we kept in remembrance these golden rules, and much perplexity and loss of valuable time would be averted. May we not all long to repeat the experiences of our earlier days of practice when *marked* and *manifest* results followed the consistent obedience to the rubric we so highly value? If, in the dearth of expedient which maintained in the earlier history of homœopathy such great results were secured as to convert thousands of sufferers from old-school practice, what splendid achievements are possible, now that we can rejoice in the fact of almost every niche in the temple of homœopathy being filled with its appropriate similimum, or specific. We need only refer to the new remedies introduced to us in Hale's invaluable treatise. And surely we owe much to the unwearied researches of modern scientists, with the increment of knowledge they have brought us. What could we do without thyroïdin in myxoedema, or the nosodes in indicated states? Then, we recognise the value of high-frequency electric currents and galvanisation. Hydropathic appliances claim our attention in many

emergencies, and from every avenue of knowledge we acquire the benefits available.

But we are in danger of diffusion of search, impairing our concentration of thought on the cardinal doctrines which characterise our body. We should never extend our labours so that they become an unharmonious, disorderly struggle, in which we lose that calm dignity and clear mastery over the sciolism which is rampant. Surely it behoves us to enquire into the reason of the lukewarm and inconsistent conduct of some who began their career under our observation ; consistent for a time, but soon lapsing into careless empirical methods of prescribing. Are we quite blameless in this matter, or is not something due to loose ways into which we may have fallen, when harassed with undue anxiety ? for, one has well said, " Beneath the surface stream, shallow and light, of what we say we believe, there flows in noiseless current, strong and deep, the very thought of what we feel indeed. Our eagerness betrays us into paths which no god attends. A strong line taken in the beginning of any given treatment will often avert many heart-burnings and regrets." The remembrance of well-directed and sustained efforts consoles us, even in untoward issues, with the assurance of having committed neither an error nor an omission, and in matters grave and vital the retrospect is gratifying.

One has well asserted that if we fail in an endeavour to make homœopathy as a purely scientific medical reform at all effectual, from a personal fear of loss as a party, then we sink the undertaking as a partisan contest, in which we shall fail of success, or drag on a puny existence, separately, instead of acting as a leaven to revolutionise the whole mass of the profession. We may surely trust to our principles and practice as *medical reformers*, through the working of the tenets we hold, to permeate slowly, but surely, the practice of medicine. Proofs of this fact everywhere abound, *e.g.*, the adoption of the single, simple remedies, dispensed by popular wholesale druggists, in form of " tabloid," pepule, capsule, palatinoid, and parvule, affording overwhelming evidence of the widespread yearning

for some more reliable scientific adaptation of remedy to disease than has hitherto obtained. *Polypharmacy* is *threatened*, *specific restorative* stimulants promise to fulfil the void, so long deplored by physicians everywhere. We can afford to wait for the triumph of the truths we have espoused, but, in order to make our leavening enduring, we must carefully guard against empirical routine, seeing such a course saps the roots of specific medicine. Generalise as much as you please the disease, but individualise the patient.

If we are desirous of influencing the medical profession we must labour in a rational and generous spirit, animated by a single aim rising superior to conservative motives, and willing to admit any evidence based on scientific truth, of therapeutic facts. New sights, which may be evolved by deeper research, together striving with zeal and energy, for the development of truth, for the consolidation of the foundations of that science on which the most beneficent of all the arts (the art of medicine) is built ; in other words, throw off the vaunted exclusiveness, in which some of us may have prided ourselves, and work henceforth as physicians. We are all familiar with the oft-repeated raillery of "trading on a name." To disprove the truth of this accusation we need only manifest an honest desire to admit new light, come whence it may, cost what it will. We are trustees of a great medical truth, which has already proved of immense benefit to humanity, modifying the previous discredited modes of healing formerly employed, establishing a craving in honest hearts for a firmer foundation on which to construct a better method of prescribing drugs than those which had maintained through the ages, and by willingly, though modestly, divulging the secrets of our success, commend the practice of homœopathy to our quondam sceptical *confrères*. We shall thereby realise that men of science are induced to follow in our footsteps in the study of the physiological action of medicines, which is the greatest test of individual freedom, and the surest bulwark of future prosperity in the healing art. Homœopathy exercises just that hurtful and



restricting influence over the minds of its partisans which every one-sided system induces. Let us aim at being rational physicians who make use of the homœopathic method in the right way and in the right place.

We know of nothing in our system which is exclusive, so that its operation affords no room for what so constantly occurs in mechanics and its applications, "the case of conflicting forces of causes which counteract or modify one another" (Mill). Homœopathy does *not* affirm "that similars *alone* are curative." It simply affirms that they *are* so, whatever other agents may be. It implies that such medicines as are given should be selected, wherever practicable, on this principle, but it leaves open to one so practising the whole range of means, the dietetic, regiminal, mechanical, and even chemical, so far as chemistry finds place in vital processes. The use of these is no makeshift, no practical expedient, in order to bring an outlying region within the scope of the system (as it is slanderously affirmed by some). The objections which apply to the ordinary applications of the geometrical method to medicine do not hold good as against homœopathy. *It* has the unity and simplicity which are the attractions of such a method, without the exclusiveness which renders it perfectly futile; it is a true generalisation arrived at by induction. Sprengel testifies "that Hahnemann, by a fine induction, demonstrated that most of those *potent* medicines known as specifics are useful just because they set up an artificial excitement which often induces phenomena very like those of the malady." Homœopathy is specific medication, and *similia similibus* is just an organon for the discovery of specifics.

In searching for the reasons of the opposition and the ostracism with which we have to contend, we recognise that there is a natural tendency in most of us to reject new doctrines and to elbow out their promoters. It is so humiliating and inconvenient after one has been accustomed to advocate a certain body of doctrines to be called upon to study and support something quite different. New truths always come, not only with an aspect of strangeness, but in apparent opposition to received and established beliefs, some-



times in opposition to views held sacred, or fundamental to all knowledge. It is the hardest thing possible for men to believe that apparent opposition has no foundation, except their own ignorance. Our system seems to be destitute of any incentives to enquiry on the part of the medical fraternity. The aversion of men to knowledge, that which one would say would promise to unite all true enquirers after truth, the ambition to develop, as far as possible, the planted garden of man, on every hand, into the kingdom of light,—this really fires the heart of the solitary man. It is sad to contemplate the contentment and incuriosity of men. Society everywhere is in conspiracy against the manhood of each of its members; the virtue most in request is conformity, self-reliance and independent thought is its aversion. It is our duty to get into shape whatever we really believe, and then to support it with all our power and influence and resources. If homœopathy is to advance in this country we, who are the custodians of its interests and desire its extension, must examine into the probable causes of the slow progress which has been conspicuous for some years past, and having done so, endeavour to arrest the decline by discovering our weak points, and applying ourselves to the reorganising and invigoration of our forces. The accusation laid against the Old School by a veteran colleague whose memory is still fragrant is true to-day, “That if we show the slightest hesitation in adopting any step tending to spread the knowledge of our better method to students and practitioners of medicine, we open the door for the enemy, who is constantly ready with the accusation that we fear to lose the distinct advantage of a distinctive name.” Hitherto we have always been able to point proudly to our readiness to diffuse the knowledge gained by experience to every person who was ingenuous enough to listen to our arguments and examine our annals. We are not desirous of mystifying, but rather of elucidating, the grounds of our faith, the methods we pursue. The public institutions in which clinical evidence can be afforded of the truth of our doctrine and the success attending its adoption are open to inspection and examination, and our Journal abounds in

practical illustrations of the effects of the small dose and the single remedy. It remains for us who have avowed our faith to be faithful to the profession we make by a consistent adherence to the principles by which we are known, to the outside world, as distinctive and characteristic.

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## DRUG TREATMENT IN THE LATER STAGES OF PHTHISIS.<sup>1</sup>

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MR. PRESIDENT, LADIES AND GENTLEMEN,—This subject conveniently divides itself under two heads, firstly, drug treatment for modifying, or, if possible, arresting the tuberculous processes at work in the lungs, and, secondly, drug treatment for relieving the various distressing symptoms peculiar to advanced phthisis. My paper is to consider the first of these two heads. So, to open the subject, I advance the proposition: *Do drugs ever arrest the disease in the later stages of phthisis?*

It is generally supposed that, except for relieving symptoms, drugs are valueless at this period of the disease, and that to arrest or modify advancing tubercular destruction of lung tissue is impossible by ordinary medication. But if it is a fact that Nature occasionally cures cases of advanced phthisis without any special treatment, surely we may hope to aid these natural processes by drug medication so long as a cure is possible? I wish, then, to raise the question to-night as to whether this can be done, and to produce evidence of apparent drug action in severe cases, and to bring to your notice one drug in particular which I have used with marked effect in such conditions. It is my hope that in the discussion some of you will help still

<sup>1</sup> Presented to the Section of Materia Medica and Therapeutics, Nov. 3, 1904.

further by giving your experiences with different remedies, and your opinions as to their action on the diseased lung tissue.

As we are only considering drug treatment, I shall take it for granted that open-air conditions and proper feeding are carried out in every case, for without these little help can be expected from medication, especially in the later stages. The cases in question are those which, in spite of perfect hygienic conditions and feeding, the tubercular processes still advance in one or both lungs, and the lung tissue is breaking down into cavities. There is progressive emaciation, or continued evening temperature, the expectoration is profuse, muco-purulent, and contains elastic tissue. Under such conditions have we any homœopathic remedies that can arrest the disease?

It is not always possible to be sure that the drug has produced the cure, for it is occasionally but rarely seen that an advanced case will take a turn for the better and get well irrespective of drug treatment. We must then experiment on a larger proportion of cases, when, if improvement sets in within a day or two, certain remedies being given, and continues in some cases until a cure results, one is justified in assuming that the drug administered has had a curative action. In my experience we have at least one drug that will frequently act in these advanced cases, and since it is but little used amongst us in this condition I desire to bring it to your notice this evening. But it will be well first to briefly review the present position of drug treatment of phthisis in both schools, to see at what point in the development of a curative system each has arrived at.

#### THE PRESENT POSITION OF DRUG TREATMENT FOR PHTHISIS IN THE OLD SCHOOL.

I am not aware that our orthodox friends have any drug which cures tubercle in the lung, when once its formation has become sufficiently advanced for positive diagnosis. On the other hand, Nature cures innumerable cases which

are never suspected of phthisis during life, as shown by *post-mortem* examinations. Beyond tonics and cod-liver oil, the only drugs generally of value in common use are arsenic and creasote, with its congener guaiacol. It is doubtful if the former really cures by itself, although, when in the form of iodide, and prescribed homœopathically, it certainly does in very early cases. Guaiacol, for which so much is claimed, seems to retard the breaking down of tubercle, to relieve bronchial symptoms, and to cause the bacilli to disappear from the sputum, but it cannot, I think, be said to cure tubercle, or to prevent its formation. But since, like all oleo-resins it is eliminated by the bronchial mucous membranes, it is a drug of undoubted value in many cases, especially those of a catarrhal nature. These drugs, arsenic and creasote, with perhaps the hypophosphites, are the only ones for which any claim of curative power can be advanced, for I need not remind you how all the vaunted cures have failed, and that the position of phthisis as to curative treatment by drugs, inhalations, injections, &c., seems to be little, if at all, further advanced than it was before the days of Koch.

#### THE PRESENT POSITION OF THE HOMŒOPATHIC TREATMENT OF PHTHISIS.

I am informed, to my sorrow, that certain adherents of our own school decline to admit that tubercle of the lung can be cured by drugs. This is contrary to my experience. A certain proportion of cases of undoubted phthisis in the early stages, in which bacilli are present in the sputum, without any change of hygiene or diet, will commence to improve directly the suitable homœopathic remedy is administered. Surely our out-patient practice affords evidence of this? Doubtless, there are many cases which do not so respond, their environment being too unfavourable. Perhaps in some we may confess failure in selecting the proper remedy, often a very difficult problem to solve. Occasionally such a case will fall into other hands and receive benefit from old-school tonics, to the detriment of our

reputation. It is certainly better to do good by tonics than to fail homœopathically, and therefore I do not hesitate to use certain so-called tonics when homœopathic indications fail. Nothing, however, does such marked and permanent good as the homœopathic specific remedy appropriate to each patient, when carefully selected. In most curable cases its administration will turn the scale, and improvement commence at once. Even when open-air treatment and extra nourishment are impossible, many cases of early phthisis are cured by such drugs as iodide of arsenic, phosphorus, calcarea carb., iodine, and others.

#### THE ACTION OF DRUGS ON THE LUNG TISSUE IN THE LATER STAGES OF PHTHISIS.

When, in spite of a good climate, with open-air treatment, perfect hygienic conditions, and suitable feeding, the disease continuously progresses, do drugs ever arrest the mischief? If lung tissue is increasingly destroyed, and, under these favourable conditions, cavities form and enlarge, with fresh areas of softening and breaking down, can our remedies do permanent good? Have we any specific homœopathic medicine for this stage? I look forward to hearing your answers to these questions, meanwhile offering you the result of my experience. Provided the lungs only are affected, and there are no symptoms of intestinal tuberculosis, we need not, in my opinion, despair of cure, for I have seen the disease undoubtedly checked and, in not a few cases, cured by homœopathic remedies. These are not usually those drugs which act best in the first stages. Though even here, any remedy strongly indicated by special symptoms may possibly prove curative. But, as a rule, beyond relieving cough and palliating pain or gastric catarrh, one seldom gets permanent benefit from arsenic, phosphorus, calcarea and other drugs, which help so markedly earlier in the disease.

Soon after commencing practice in Bournemouth, I was confronted with so many cases of advanced and seemingly hopeless phthisis, that after trying with little results

remedies usually recommended in this condition, I began a search *de novo* through our Materia Medica, to see if any drug provings contained symptoms in any degree suggestive of this condition. This was not done in the expectation of finding there signs of advanced lung mischief, except possibly in poisonings, but my hope was for indications that if it were pushed to extremes some poison might possibly produce actual lesions resembling late phthisis. The first drugs that arrested my attention in this connection were iodine and gold. The poisoning cases in the "Cyclopædia of Drug Pathogenesis" certainly suggest that, if pushed to extremes, conditions somewhat resembling advanced phthisis might result from their use. I need not remind you that these drugs are of value in all stages of phthisis, and also that they have been celebrated as used in a certain supposed cure for the disease known as the Shurley Gibbes' treatment. Certainly I find iodine in 5-drop doses of the 1x. tincture, given in milk, of distinct value in advanced cases. But I do not think it has ever cured a case in my hands. Much the same may be said of *aurum*, which seems to act best as the *iodide*, in 1 or 2-grain doses of the 2x. trituration. This drug has a more decided action on lung tissue than iodine, and will sometimes start remedial processes in apparently hopeless cases. But its action is very uncertain. However, with the exception of the drug I am about to mention, iodine and aurum, and their combined salt, seem to me to have more effect upon the lung in late phthisis than any other drugs that are usually recommended.

#### A MORE PROMISING REMEDY FOUND.

Continuing a search in the Materia Medica, I soon perceived that *stannum* stood prominently forward, having—as you know—a number of definite chest symptoms, bearing a close resemblance to those of advanced phthisis. These have been long recognised by homœopaths, and have led to its use in bronchitis and in so-called catarrhal phthisis, also in the early stages of pneumonic phthisis, but it is not

usually recommended in late phthisis. The provings of stannum in the Cyclopædia are not very helpful, but in the *Materia Medica Pura* Hahnemann has recorded a number of most suggestive symptoms. He mentions also that powdered tin was the basis of a quack remedy for consumption, largely used in his day, and he credits it, apparently, with cures of advanced cases. There can be no doubt that *stannum* produces a more perfect picture of the later stages of phthisis than any other drug in our pharmacopœia; and it is probably only by the stethoscope and microscope that the difference between a condition of severe and prolonged tin poisoning and one of advanced tuberculosis could be distinguished. Although this condition is probably only catarrhal, one might reasonably expect it to run into true phthisis in a person of tuberculous tendencies, for bacilli would soon find a nidus under such favourable conditions. It seems to me that this is the nearest approach to the production of tuberculosis by a drug poison that we are likely to attain. However this may be, the same apparent similarity obtains between the symptoms of stannum poisoning and phthisis that has led to the successful use of all our homœopathic remedies. With reference to symptoms so marked in advanced phthisis, I may mention that stannum produces profuse muco-purulent expectoration, progressive weakness and emaciation, with evening fever and severe night-sweats, a combination of symptoms not found in the pathogenesis of any other drug with which I am acquainted.

Having decided that, by the law of similars, stannum promised good results in late phthisis, the best mode of using it had to be ascertained. From the analogy of other drugs useful in this disease, it seemed probable that one of the salts of tin would act better than a trituration of the metal. Of its various salts the iodide first suggested itself, for, with the exception of phosphorus, none of the non-metals produce symptoms resembling phthisis so closely as iodine. But the phosphides are unstable, and phosphates do not retain the power of the metallic radicle. Therefore iodides, having neither of these objections, are generally more



useful. This is confirmed also by our experiences with the iodides of arsenic, and also of gold, as well as by the pronounced action of iodine itself. Stannum iodatum was therefore selected for experiment on these theoretical grounds, and six years ago I first commenced using it in the later stages of phthisis. The results in a large number of cases have been distinctly satisfactory, and when other remedies failed I have again and again seen reaction occur under stannum iod., and improvement set in, even in some apparently hopeless cases, so much so, that since that time it has taken the same place with me in the treatment of advanced phthisis that iodide of arsenic takes in early phthisis; whilst iodide of gold occupies an intermediate position. These three drugs are often my sheet anchors in the treatment of this disease. And although I have used stannum in early phthisis it has usually disappointed me, except where the peculiar bronchial symptoms were present; but in later phthisis it has given me many gratifying successes, no other drug seeming to have so marked an action on breaking-down lung tissue. When there is no tubercular enteritis, and the evening temperature under open-air conditions does not exceed  $102^{\circ}$ , I nearly always obtain some effect from its use, which soon becomes evident to the stethoscope by improvement of lung sounds, decrease of expectoration and lowering of temperature. Of course, this improvement is often only temporary, although sufficiently marked to show the power of the drug. Nevertheless, a certain proportion of apparently hopeless cases not only begin to improve directly stannum iodide is given, but continue to do so, and make more or less real recoveries. I can recall several such patients who are alive at the present time after some years, and whose lives, in my opinion, were saved by the use of this remedy.

#### METHODS OF ADMINISTRATION.

The higher potencies, often of great value in chronic diseases, have failed to assist me in advanced phthisis, and the best results generally come from such doses as can be



taken without producing any physiological effects. This applies to all three iodides—of arsenic, gold and tin. Stannum iodatum in the 2x trituration, 1 to 3 grains three times a day after meals, is my favourite prescription. In one or two cases I have found this produce gastric irritation, when the 3x can be substituted with benefit. If after a week of this no effect is noticed I give 5 drops of iodine 1x tincture in milk three times a day. This seems to start and supplement the action of stannum in a very marked degree, and will start healing processes in the lung which iodine could certainly not do by itself. I look upon this effect much in the same light as that of sulphur in chronic diseases in waking up dormant drug reaction. The iodine perhaps assists by its action on intestinal glands, which it may stimulate and strengthen, increasing their power of assimilating stannum. My observations indicate that tubercular enteritis, which seals the doom of so many victims, rarely attacks those who have taken a good course of iodine, and that the use in the later stages, even of fatal cases, usually prevents the occurrence of tuberculous diarrhoea.

#### CONCLUSION.

I shall not take up time by reading notes of cases apparently benefited by stannum iod. It is of little use to detail cases in phthisis. Owing to the fact that patients occasionally get well in all stages of the disease, irrespective of special treatment, it is difficult to arrive at results by statistics. It is a fact that every new treatment or remedy recommended for phthisis, however useless or even absurd it may finally prove, has at first been bolstered up by elaborate accounts of supposed cures. The only drugs that are of real help have been proved to be so by the united observations and opinions of many medical men, and so have received general recognition. It is by this test alone that my views as to stannum iod. must stand or fall. Those of you who know something of the work done at Bournemouth, especially at the Hahnemann Convalescent Home, will be able to judge whether the ideas I have

advanced are worthy of attention; and my hope is that you will try the remedy yourselves, and presently acquaint us with your results.

Until the publication of our valued colleague's (Dr. Clarke) "Dictionary of Materia Medica," I was not aware that the iodide of tin had been previously recommended in advanced phthisis, but I am interested to find my ideas independently corroborated by two American physicians, Dr. Haines and Dr. Youngman, both of whom have used the drug with marked success in certain cases.

In conclusion, I may briefly suggest the ideal treatment for advanced phthisis, according to the present state of our knowledge, as follows: (1) Absolute open-air treatment in the best climate obtainable. In this country Bournemouth or Ventnor are undoubtedly first; high altitudes, and especially bleak hill-tops, being strongly counter-indicated in our climate. (2) Full feeding—or super-alimentation—according to the digestive powers of each patient. (3) The administration of the homœopathic specific remedy most suitable for each case, but which, in the absence of other indications, will frequently, I think, be found in *stannum iod.*, with or without the addition of iodine. More cases of this often hopeless, and always terrible, disease appear to me to recover under these conditions than under any other methods of treatment that have come under my observation.

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Dr. DYCE BROWN, in opening the discussion, said that he had never systematically used *stannum* in cases of late phthisis, although he had used it in other circumstances. He had never used the iodide of tin, but he thought that drug should be well tested in order to ascertain its merits fully. He remembered a case of galloping consumption, where the physical signs were well marked, where he gave iodine in the 3rd decimal dilution three times a day; an improvement took place after a few days, and the patient steadily progressed, until she became perfectly well.

Dr. CLARKE said Dr. Ord had given in his paper some valued experience of his own, which was the kind of thing they wanted at the Society. It was quite legitimate in homœopathy to make

use of the imagination, and it was quite legitimate to use the individual effects of two remedies combined in chemistry in the way Dr. Ord had done in selecting the iodide of tin in preference to any other preparation of tin when he wanted to get the effects of the metal. They were sometimes apt to be narrow in their views of what homœopathy was. Homœopathy was a very elastic thing; it could be used on crude indications or on high indications, and it was perfectly legitimate for prescribers to make their choice of what indications they would use. If they were practising homœopathy on broad indications it would probably be safer to come nearer the crude drug in prescribing; if, on the other hand, they were using homœopathy with fine indications in individual cases, better results were probably obtained by going pretty high. It was also quite legitimate to practise homœopathy from the clinical side, as Dr. Ord had done, in taking the main conditions that were present in all cases of advanced phthisis and selecting the drug that came nearest to the picture. This was very much on the same lines as Hahnemann worked on in selecting the remedy for the genus epidemicus of any malady prevailing for the time being. In that way a good deal of trouble could be saved by generalising. But in order to make their generalising effective, homœopaths must be able to individualise first, and individualise last, if necessary. He (Dr. Clarke) asked if Dr. Ord had used tuberculin in cases of advanced phthisis. In the latest stages of phthisis he had noticed that tuberculin was apt to leave aggravation; but in other cases it had done very good service.

Dr. STONHAM said he had never used stannum iodide, although he had used stannum, being principally led by its night-sweats and expectoration. Quite recently he had been treating a case of phthisis where night-sweats were troublesome. In order to alleviate that symptom he gave stannum 12, and was surprised to find how the patient's condition was improved in temperature, expectoration and night-sweats. An interesting point made by the author was the fact that sometimes when stannum iodide had not taken effect an additional dose of iodine in milk caused the drug to have its usual beneficial effect. Might not that be because the iodine acted, not in stirring up the system, but simply in rendering the stannum more soluble? If stannum ioxide 2x were given, and anything occurred in the stomach to decompose the drug, letting the iodine free, a certain amount of stannum in a very insoluble form was in the stomach, whereas by adding an additional amount of iodine the iodide of stannum was preserved, which

must be more soluble than the pure stannum. He thought possibly some of the good done might be due to the chemical action produced in that way. Nearly all of them now used tuberculin in cases of phthisis at some stage or other, and with a certain amount of benefit, in his experience. He generally gave tuberculin 30 once a week, early in the morning, and in the great majority of cases on questioning the patients he found they were not quite so well; they were more languid and tired, and generally had more cough and expectoration, showing distinct aggravation, but on the following day they were usually better.

Mr. DUDLEY WRIGHT spoke from the pathological point of view with reference to the question of tuberculinum. Dr. Clarke had mentioned that he found tuberculinum useful in the later stages of phthisis. He (Mr. Wright) gathered from a personal communication he had received from Dr. Ord that he was not favourably impressed with its action in cases of advanced disease. He (Mr. Wright) believed the explanation was that in the later stages of phthisis it was not only a question of tuberculous infection, but of a mixed infection of both staphylococcus and streptococcus. If cases were to be improved at all by the administration of the toxins produced by the various bacilli which attacked patients, they must be treated with the toxins both of the tubercle and of the other germs which were included in the diseased process.

Dr. CLARKE said that bacillinum contained all.

Mr. DUDLEY WRIGHT, continuing, said that Dr. Clarke had raised a very important point. Personally he was not aware that any direct experiments had been made with bacillinum, nor that it had been carefully examined to see what it contained, but if Dr. Clarke and others were satisfied with it, well and good. If anybody would like to try a preparation, which was made with some knowledge as to what it did contain, there was such a preparation in the laboratory of the British Homœopathic Association, one made from a pure culture of human tubercle combined with a certain amount of staphylococci and streptococci in broth, from which any dilution desirable could be obtained. At present no experiments had been made with this preparation. By the genius of Professor A. E. Wright, late of Netley, now of St. Mary's Hospital, a method had been obtained by which the amount of improvement which took place in the blood in the direction of phagocytosis or the destruction of the various bacilli by the patient's serum could be actually registered. That was of the very greatest importance. During the coming winter it was hoped

that experiments would be made in the laboratory by the aid of this method, but at present the stock of culture was not quite complete, as it took three or four months to get the proper amount, and the proper strength; but he hoped before the summer session began certain data might be obtained to go upon, and that they would know what action stannum actually had on the blood of the patient. Dr. Stonham had raised a very important point with regard to the aggravation which took place under the administration of tuberculinum. Professor Wright had shown that when the toxin of staphylococcus or streptococcus was injected into a patient, the patient had what was called a negative phase of his phagocytic power, *i.e.*, supposing his white blood corpuscles were each capable of taking up a dozen staphylococci before the injection, for a few days after the injection of the poison the white corpuscles were actually worse off with regard to their phagocytic powers than they were before, *i.e.*, a negative phase occurred in which the white corpuscles were unable to account for more than two or three staphylococci; but after a period of three or four days a positive phase took place, and during that positive phase the patient's power of destroying the staphylococci increased very considerably up to a certain point. If another injection was made, a drop again took place and then another rise, until finally the rise was pretty well maintained. That, again, was one of the numerous illustrations they had from old school sources of the homœopathic action of remedies, and he hoped they would be able to make some use of that knowledge. The whole subject was one which had only just been properly worked out by Professor Wright and his colleague, Captain Douglas, of the Indian Medical Service. He (Mr. Wright) had had the opportunity of going through the process with them, and seeing the method they pursued, and hoped during the coming winter to carry out some of their methods in the laboratory of the Association. One of their first objects would be to try such drugs as iodide of arsenic, iodide of lime and iodide of stannum, which the author had mentioned in his very interesting paper.

Dr. WATKINS said that he had also been interested in Professor Wright's work in studying tuberculosis from the blood point of view. Professor Wright found in making his observations that the phagocytosis did not depend so much upon the potency of the leucocytes as it did upon the blood serum. He found that the blood serum contained certain substances which were bacteriotropic; which produced a certain effect upon the tubercle

bacilli, by means of which they became more readily susceptible to the leucocytes; and then by introducing a certain substance into the blood, more especially Koch's tuberculin, he was able to raise the bacteriotropic action of the serum very much indeed. Professor Wright gave it the name of opsonic, from the Latin word *opsono*—I cook, I prepare pabulum for. The system of registering the opsonic action was a very ingenious one, and it was possible to test the effect of any drug; it gave a more delicate reaction than the stethoscope, or the observation of the temperature curves, and so on.

Dr. SEARSON asked whether Dr. Ord had any rule which would guide them in deciding whether a patient with a temperature could be allowed out of doors, and if so, what the temperature was? He saw one of his patients three weeks ago, who then had a temperature of  $102.4^{\circ}$ ; he confined him to his room in bed, having all the windows wide open, and the temperature went down to  $99^{\circ}$  in the evening and  $97^{\circ}$  in the morning. The patient had been out for the last three days, and the temperature had gone up to  $101.4^{\circ}$ . What course should be adopted in such a case? He gave the patient tuberculinum 200, once weekly, which appeared to be very helpful.

Dr. BYRES MOIR said he had had two experiences of the aggravation caused by the use of tuberculinum. The first was in an old case of pleurisy, followed by hard tuberculosis in the lungs, but for some weeks there had been no rise in temperature above  $99^{\circ}$ . He gave the patient one dose of tuberculinum 30, and the temperature rose the same day to  $103^{\circ}$ ; it then fell, and for a week afterwards there was no rise. In the second case he gave a patient, who was suffering from glycosuria, with phthisis in both lungs, one dose of tuberculinum 30, with the result that within two hours of the dose there was a decided chill, and the temperature rose to  $103^{\circ}$ .

Dr. LAMBERT said that he could bear out what Dr. Searson had said. In almost every case of phthisis he gave tuberculinum 200, once a week, and had never had a patient complain, in fact, a number said they felt better after the weekly dose. He generally gave it at night.

Dr. GRANVILLE HEY raised the point as to how drugs acted. When he first became House Physician at the Hospital he used to wonder why arsenicum iodide was given, seeing there were no definite provings of the drug, although to a certain extent the action of arsenic and the action of iodine were known. The same remarks applied to tin, iodine, or gold. Were they justified in de-



ducing because arsenic produced one effect and iodine another, that when given in the compound they would produce their individual effects? Chemically one knew that compounds, as a rule, had very little resemblance to their component elements. If, then, their physical characters were very much changed, were they justified in expecting the compound drugs to produce the individual effects of their constituents? If so, were the drugs again reduced to their component parts in the body?

Dr. ORD, in reply, thanked the members for the kind reception they had given his paper; he considered the discussion which had taken place would be of far greater value than anything he had said. His experience of tuberculin was that if a dose of 30 or anything under 30 was given, aggravation was frequently caused. He had not used it above 30. He had always been disappointed with tuberculin; a reaction might be obtained, but he had seldom seen any genuine effects from its use in the doses in which he had given it. To a great extent he had ceased using it, because his experience was that it failed to exercise any curative action in advanced phthisis, although it might do so sometimes in early cases. He thought the reason was the one suggested by Mr. Dudley Wright, that tuberculin was not homœopathic to the condition of advanced phthisis, but it was to some extent to early phthisis.

Dr. CLARKE asked Dr. Ord which preparation he used.

Dr. ORD replied that he used Koch's. It seemed to him that it was only homœopathic to the tuberculous part of the poison, and in advanced phthisis that was of the least importance. Patients did not die so much from tuberculosis in advanced phthisis as they did from septicæmia. This was shown by a case he had under the action of stannum iodide, in which the patient's lungs were improving under the stethoscope, also with regard to the amount of expectoration, and so on, but the patient was dying while her lungs were improving. The fact was that many patients died from secondary septicæmia, and not only from the tubercular condition of the lungs, and for that reason some preparation was required, such as Mr. Dudley Wright has suggested, which contained the products of all the poisonous elements in the case as far as they could be obtained. Bacillinum might fulfil this condition, tuberculin did not. Dr. Hey had raised the question as to whether they had the right to assume that drugs used in combination could be used homœopathically without any provings. One did so only with such drugs as had symptoms pointing in the same direction; one would

never combine two drugs having opposite sets of symptoms. He preferred the iodides of arsenic, gold and tin for the reason he gave, that iodine had a large number of symptoms corresponding to phthisis, and that with the two drugs together more powerful action was obtained than from arsenic, gold, or tin, by itself; the one supplemented the other, because all the symptoms were pointing in the same direction. He thanked Dr. Dyce Brown for mentioning the case of advanced phthisis, which was apparently cured with iodine; it was very interesting and bore out what he had said. He sympathised and agreed with Dr. Clarke's remarks as to high indications or low indications. He carefully said in his paper that he limited the use of tin to those cases in which there were no decided indications for any other drugs. He hoped he was a homœopathist first of all, and his homœopathicity extended to any drug that would cure, even in advanced phthisis, if he could find it, but when he failed to find a drug which was indicated he fell back on a drug which one hoped would be homœopathic, because of the general condition of things rather than the more minute symptoms. In reply to Dr. Searson, when patients had a high temperature, *i.e.*, over 100°, absolute rest of the lung was desirable. If he had patients with a temperature of over 100° he stopped them walking about, put them in bed, and kept the lung at rest. Fresh air was the best thing the patients could have in all stages, no matter what the temperature was. Provided they were kept perfectly warm in their bodies, it did not matter how cold the air might be that they breathed.

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## THE ACTION AND THERAPEUTICS OF STRYCHNINE.<sup>1</sup>

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It almost needs an apology to bring before the Society such a well-known drug as strychnine, but because it has been neglected in text-books on homœopathic materia

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medica, and there has not been a discussion (so I have been informed) in this Society for a long time, I venture to hope that a mutual exchange of views will help some of us in our practice.

The earlier *materia medica*s did not include strychnine separately from *nux vomica*, and the later ones devote to it less attention than it deserves. There are six pages of provings in the "Cyclopædia of Drug Pathogenesis," and of course numerous cases of poisoning.

The provings were made with the liquor strychniæ of the British Pharmacopœia (4 grs. to the ounce), and seem to be of a rather heroic character, the first prover taking nearly an ounce and a half in fifteen days.

The symptoms produced were distinct, and may be summarised thus: First prover had for several days stiffness and trembling; then developed, on twenty-third day, dizziness, humming in ears, "general coldness, especially in sacral region, which feels as if it were iced." Second prover on third day had severe, sharp pains in shoulder-joints and muscles of chest, a cold chill down entire length of spine, and afterwards felt deathly cold, giddiness and nausea, great weariness, and other dull pains and spasms when falling asleep. Same prover on another occasion, two days after taking thirty drops, had "violent bursting headache, burning heat in eyes, contracted feeling in muscles of neck, icy coldness down head and spine, feverish thirst, nausea, intense aching of feet when walking." A week later the same dose produced marked tremor and giddiness, sudden cold, perspiration, and icy coldness over body, and, later, intense burning of ears, nose and eyes, depression, stupor, and at night restlessness, with profuse perspiration.

Other symptoms are common to *nux vomica* and strychnine. Of the poisoning cases I need only refer to those where the doses were moderate and not fatal, *e.g.*, "Mr. B., afflicted with chronic tic douloureux in paroxysms of excessive violence, and accustomed to take morphia, took by mistake  $3\frac{1}{2}$  grs. of strychnine powder. When walking along the street he complained of numbness in back and legs, followed by dragging of muscles of the legs, so that he

suddenly overbalanced and fell heavily backwards, but there was no spasm. After a second dose of the powder he was seized with a violent tetanic spasm affecting the legs and muscles of respiration. At the conclusion of the spasms, which recurred for some hours, the patient was left in an excessively exhausted state, and was unable to turn himself in bed." He quickly recovered, and the attacks of *tic douloureux* *never returned*.

In another case turgescence of the capillaries of the face and a decided increase of surface temperature were observed, so that the man looked drunk. The most distressing symptoms was generally the extreme dyspnœa from spasm of respiratory muscles.

The chief pathological appearances after fatal cases are: (1) Sanguineous effusion in spinal canal. Membranes strongly injected. Substance normal. (2) Heart flaccid and friable. (3) Flesh of muscle soft and doughy.

Its physiological action is stated to be increase of reflex excitability of spinal cord and nerve centres, both vaso-motor and respiratory. Small doses do not seem to affect the motor nerves in experiments on animals, whilst large doses paralyse them, and Brunton says the paralysis is not entirely due to the exhaustion from the convulsions.

The special actions of strychnine, according to Brunton, in small doses are the following: The brain is excited, its action stimulated like from alcohol or caffeine. Respiration is quicker and deeper, and expectoration is promoted. The heart's action is increased and blood pressure also. Hearing and smelling are more acute, and there is an increase of saliva and appetite. Increase of movements of stomach, and peristaltic action of bowels.

There is no medicine of more general action than strychnine, and none with better defined symptoms. If any medicine may be called a general stimulant of vitality it is this one, and well merits the distinction of polychrest bestowed by Hahnemann on *nux vomica* as "one whose symptoms correspond in similarity with those of the commonest and most frequent of human diseases."

Hahnemann adds: "In this, as in some other medicines,

we meet with symptoms which seem to be completely or partially antagonistic to one another, *alternating actions* which at the same time are *primary actions*."

Hale controverts this latter statement in reference to *strychnine*, and calls the increased reflex excitability of the spinal cord and the spasms as primary, and the subsequent exhaustion and paralysis as secondary, adding that massive doses cause death in the first spasm, and in the case of the frog without spasm at all.

I think, myself, that strychnine may well be brought into line with other drugs which stimulate functional activity in that over-stimulation is followed by depression, but it is singular in its action as stimulating all the nerve centres.

It may be compared, however, with other drugs as regards its action on a single organ. For instance, strychnine and digitalis both stimulate the cardiac muscle, and render its contractions slower and stronger, but in poisonous doses strychnine causes extreme rapidity and weakness of the pulse, and with digitalis the pulse becomes weak, rapid, and irregular.

Again, strychnine in small doses causes increase of appetite, and more complete evacuation of bowels. In larger doses it produces (prover A. F., Encyclopædia) griping pains in bowels and constipation, like *nux vomica*.

In small doses strychnine causes deeper and more complete respiration, and in larger doses spasm of the muscles of respiration with suffocation, which finds its analogue in arsenic.

Moderate doses of strychnine stimulate brain activity, while the provers complained of (1) considerable confusion of ideas, general drowsiness and headache; (2) a dull pain in head and eyes, with feeling of stupor and great weariness and loss of memory after 25 drops; (3) and extreme lowness and gloom (after 30 drops). Here it resembles alcohol.

In a similar manner the icy coldness complained of by all the provers was followed in the first prover by a fever of an adynamic intermittent type; in the second and third provers by burning heat in eyes with feverish thirst, and in others by

intense burning all over and perspiration, forcibly reminding us of aconite.

Again, the spasms and convulsions in cases of strychnine poisoning are followed by intervals of exhaustion without any uneasy sensation, and some touch or movement is generally necessary to excite the spasms afresh. Moreover, they are of a clonic character, beginning with rigidity, proceeding to spasm and cramp, and followed by entire relaxation. Atropine has a similar action and reaction.

In some cases there seems to be an alternation of symptoms, but there is to be noted, as a rule, a decided action, followed by a reaction in the opposite sense, or stimulation and depression.

If this be acknowledged, there will be no difficulty in admitting strychnine into the list of drugs which may be prescribed under the Hahnemannian formula not in substitution of nux vomica, but for somewhat different and distinct morbid conditions. The range of its action is not so great as nux vomica in gastric disorder, and in my experience its therapeutic effects are manifest in doses just short of the production of its physiological action, at all times observing the sound rule of the latter being entirely absorbed by the former.

#### THERAPEUTICS.

The action of strychnine is so associated in one's mind with spasm that one is apt to forget the symptoms both preceding and following the spasmodic state. I propose to divide them into three stages: (1) Excitability, (2) spasm, and (3) exhaustion, and to consider some of the diseases corresponding to each stage.

(1) *Stage of excitability*.—I put in this category three diseases which strike me as analogous. Headache, hysteria, and insomnia. The kind of headache I find benefited by strychnine is of a spinal character spreading from the nucha over the head and not associated with gastric disorder, but accompanied by some exhaustion, dulness and stupor, alternating with excitability.

The insomnia often arises from similar cause. When a patient is too tired to sleep and the brain is oppressed, probably indicating vaso-motor dilatation, strychnine often acts like a charm.

In hysteria, strychnine competes with ignatia in its action. Where the symptoms are more chronic and associated with asthenia or anæmia, strychnine has a more powerful and lasting effect than the latter medicine.

(2) *Stage of spasm*.—Much has been made of the want of success of strychnine in tetanus as an argument against the doctrine of Hahnemann. There is some evidence in its favour, however, but I would point out two facts which must be taken into account, viz., the spasm of strychnine is of a clonic character, with complete relaxation, and needing some slight excitant to renew it, whereas tetanus spasm is tonic, with incomplete relaxation; and, secondly, the toxins in this disease become fixed in the central nerve cells, and are not likely to be reached through the blood (Whitla). On the other hand, considerable success has been recorded of the administration of strychnine in other spasmodic diseases. Trousseau lauds it in chorea, and gave largish doses. Eustace Smith recommends it in chorea, as well as for the reflex convulsions in growing boys and girls (1 or 2 mins. of liquid strychnine with ergot), and it has been given with curative results in idiopathic epilepsy and in writer's cramp. Laura says, in his "*Pharmacotherapie Dosimétrique*," that its effects are marvellous in the latter disease, and I think the resemblance of the symptom to those produced by strychnine is very close.

(3) *Stage of exhaustion*.—It is for diseases, and they are numerous, resembling this stage of strychnine poisoning that the drug is most frequently exhibited.

In paralysis of various forms and paresis, strychnine rivals electricity in its effects. In diphtheritic paralysis it is perhaps the only remedy to be depended on. In atony of the bladder and of the bowel, and in prolapsus of rectum or anus, it is indicated and is reliable. In convalescence from acute disease it is, in my experience, the principal

remedy to keep in mind. It stimulates appetite, and like no other drug in the pharmacopœia, helps to restore tone to the muscles and promote a feeling of health. Its good effects are also well seen in exhaustion from incurable disease.

In the weakness of old age I am accustomed to rely greatly on strychnine administered from time to time for long periods. I cannot say that it prolongs life, but it seems to stimulate both the mental and the physical functions on which so much of the cheerfulness of life depends. Where it agrees, therefore, it is a valuable medicine.

In the exhaustion so characteristic of many cases of anæmia and chlorosis, strychnine is almost as indispensable as rest, and I could relate many cases which did not respond to iron or arsenic, but quickly mended when strychnine was added to the iron.

(2) *Nerve centres*.—Strychnine in the course of poisoning the nerve centres simulates many diseases, and is accordingly curative of these conditions.

In the cardiac sphere it is a powerful remedy in cardiac weakness, muscular atony, dilatation and feeble pulsation, as well as exhaustion from acute disease.

In the respiratory sphere I have found it most useful in dyspnoea, chronic asthma, emphysema, congestion of bases of lungs. In brain disorder I have found it relieve sleeplessness from exhaustion and depression from over-work. In stomach complaints it gives place to *nux vomica*, but in sea-sickness it is sometimes valuable as a preventive, and it is recommended in neuralgia of gastric plexus with spasm.

The action of strychnine on the vaso-motor centres is worthy of further study. It greatly increases the normal tone of the blood-vessels, as well as the reflex excitability of the nerves, and the blood pressure is raised in experiments on animals, so much so as to keep this up even when the cord is separated from the medulla. When this goes into spasm we get the icy coldness complained of by the provers, but which is followed by relaxation, with fever or sweating, and finally profound exhaustion. The diseases I would mention as corresponding to these conditions are cholera, collapse and influenza, and the acute stage of some inflammations.

Some cases of influenza strongly resemble the symptoms and course of strychnine, and I cite here two cases where I gave strychnine with very satisfactory effect.

*Case 1.*—C. J., aged 72 years, a feeble old man of the nervous type who was very susceptible to chills and suffered from rheumatic pains on change of weather. He had been in fair health for the past few months. His wife had an attack of influenza of the abdominal type a fortnight previously without fever, and had entirely recovered by September 26. Without any exposure he experienced a sudden chill on October 3. I saw him on the 5th, and he complained of extreme rigors and icy coldness, with pains in head and down spine. His face was flushed and perspiring. His bed was piled with blankets and yet he was shivery and restless. His pulse was small and irregular, and his temperature subnormal. He had sickness, bilious vomiting and loose dark stools. He had a great deal of nervous apprehension, and spasm of throat of a nervous character. I gave him aconite, followed by veratrum. On October 6 the diarrhoea and sickness were relieved, but the pain, low temperature, and sensation of coldness persisted. It struck me that this was just a strychnine case, so I ordered a half milligram dose of the arseniate every two hours for eight doses, equal altogether to about  $\frac{1}{18}$  grain. The next day there was considerable reaction. The temperature went up to 99.8°, the pain disappeared, and the pulse became fuller. A few doses of aconite were given, and then the strychnine was resumed, and recovery was very rapid, the patient getting up and walking three days afterwards with a vigour which surprised me. There were no apparent symptoms produced by the strychnine, the whole physiological action being absorbed by the therapeutical, and the spasm of throat disappeared during the continuance of the drug. The sequence of symptoms in this case seemed to correspond very closely to the first and second stages of strychnine, viz., excitability and spasm, hence the stage of exhaustion was much less marked than usual, and recovery correspondingly rapid. This is not an unusual case of influenza, but I do not recollect ever seeing strychnine pointed out as the homœopathic remedy for it. If you agree with me that it is so I feel confident you will use it, and with success.

*Case 2.*—Mrs. S., aged 50 years, sent for me on February 8, with acute symptoms, weak and rapid pulse and severe pains, rigors, and temperature of 101° F. One dose of 8 grains of anti-pyrin was given first to relieve the pain, and was followed by



gelsemium during the night. The next day the pains were subdued, except some headache, and the temperature reduced to 99°, and there was perspiration. Strychnine was then given on account of the great exhaustion in doses of 1 milligram, or  $\frac{1}{8}$  of a grain, three times a day, and belladonna by night for the headache which persisted. On the 12th there was a recrudescence of fever. Temperature 102.5°, and strychnine was resumed, with gelsemium at night. On the 13th the temperature fell to 99°, and did not rise over 100° afterwards, strychnine being continued for several days in same doses. There followed a very distressing cough, with congestion of larynx and bronchi, needing several remedies, kal. bich., drosera, hyoscyamus and rumex in turn; also great heart weakness, for which caffein was prescribed. Strychnine was continued for the great exhaustion, but the patient was practically well by March 1, or three weeks after the beginning of the attack, which period contrasts very favourably with similar cases which I have treated without strychnine where the symptoms were of equal severity.

Strychnine should not be forgotten in cholera, and in collapse from other causes it is too well known to need special remark, except that to get the effect rapidly it needs to be injected hypodermically or *per rectum* in doses of from  $\frac{1}{20}$  to  $\frac{1}{10}$  grain.

Hahnemann recommends nux vomica in chills, saying, "Serious ailments from catching cold are often removed by it." This is more true of strychnine, and I think it is indicated in the cold stage of fevers and acute inflammations, more especially pneumonia.

I would add one word more respecting the action of strychnine on the muscular system. Brunton says, "Small doses do not affect the motor nerves, large doses paralyse them. This paralysis is partly due to exhaustion from the convulsions, but not entirely, since if one sciatic nerve of a frog be divided before poisoning, so as to prevent any convulsions in that limb, it still loses its irritability, though not so soon as the undivided nerve." This paralysing effect on the motor nerves was well seen in the case of poisoning before mentioned, where the first prominent symptom produced in a man, who had by a mistake swallowed  $3\frac{1}{2}$  grs. of strychnine, was a sense of numbness in the



back of the legs, the numbness being accompanied soon by a want of power and dragging of the muscles of the legs, which became so great that, as he described it, he had to put his hands at the back of his thighs in order to push his legs along. This occurred before there was any spasm.

I argue, therefore, that when prescribing strychnine in small doses for this muscular inertia, which is such a common symptom, not only in general debility, but at the beginning of acute disease, I am giving a drug which directly causes this symptom in a large dose, and is therefore in homœopathic relation to it.

There are several other diseases in which the exhibition of strychnine has been attended with striking results, and which are more or less in the relation of a simile, such as facial neuralgia, alcoholism, sexual weakness, and enteric fever, but I have no experience in those diseases worth recording. In reference to the last-named disease it is worth while to notice a statement of Professor Hare, of Philadelphia, who says (*Medical Annual*, 1903): "With the continued administration of strychnine in the course of prolonged exhausting disease" such as typhoid fever, the drug "fails after a certain length of time to produce a true stimulant effect, and simply produces nervousness and tachycardia." He has also noticed a form of delirium taking the place of the usual twitching spasm resulting from too large doses of strychnine.

#### THE DOSE.

Finally, what is the best dose for the administration of strychnine?

My own practice has been mostly with substantial doses, either drops of the liquor of the British Pharmacopœia or granules of the arseniate, or the hypophosphite, but I have occasionally met with headache in consequence, though never in an acute case. I think the patients needing smaller doses are probably those corresponding to the first stage of strychnine action—the stage of excitability. At the other

end of the scale the condition of profound exhaustion or collapse is to be met by the injection of much larger doses, whilst diseases corresponding to the spasm may need doses at one time small and at another moderate. I have rarely noticed aggravation of symptoms follow a moderate dose of strychnine; indeed, not so often as with *nux vomica*, which occasionally produces unpleasant symptoms in pilules of 1x dilution.

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Dr. JOHNSTONE (from the chair) said he was sure the members felt indebted to Dr. Nicholson for having come such a long way to present his interesting analysis of the therapeutics of strychnia. Strychnia was a drug he personally had used very much empirically, relying more upon it as a stimulant in cases of depression and exhaustion than upon its homœopathic employment. It was well that such papers should be read, reminding them that there were homœopathic uses for drugs which, like strychnia, were widely used in other ways.

Dr. DYCE BROWN referred to the point alluded to by the President, namely, the use of strychnia as a stimulant in cases of debility and weakness. There was not the least doubt that this drug was a most valuable remedy in certain cases of debility and exhaustion from an acute illness, during convalescence. He thought Dr. Nicholson was hardly right in dividing the physiological action of strychnia into three stages. He (Dr. Dyce Brown) looked upon the symptoms beginning with the mild form of excitability, going on to the spasm, and finally to the exhaustion, as simply an increase of the same type of physiological action. There, he thought, they had the *rationale* of its use in what might be called a "tonic" in cases of debility. The small dose was used, developing a primary action, which was not usually perceived in cases of poisoning, and in cases of provings large doses were used. In the latter cases the physiological symptoms gradually developed, increasing according to the severity of the dose; and the primary effects, which were made use of when the medicine was used as a "tonic," were those that were not noticed, generally speaking, in the proving. The whole range of increase in quantity from the excitable condition to the spasms and exhaustion was the field in which they looked for the use of strychnia. And in the most general view it could thus be regarded as homœopathic to those states in which it acted as a

“tonic.” Excitability and spasms were really indications of depressed nerve power, and were naturally followed by exhaustion, so that all through its action strychnia was homœopathic and not allopathic as a nerve “tonic,” if one may use the word, and hence the benefit received from it.

Dr. GOLDSBROUGH thought they must hesitate to regard the appearances which issued from the effects of strychnine as opposite states. They were consecutive states, contrasted appearances, but all induced by the action of the drug, the normal state being the equilibrium which obtained between the contrasted states. In giving the drug as a medicine they should consider the whole range of its action rather than one phase of it, and consider also, taking the whole series of symptoms into consideration, whether the drug was being given homœopathically or not. He was somewhat surprised to hear Dr. Dyce Brown bring this point forward, because it seemed to him to rather go against his former exposition of the action of homœopathic remedies as opposite in large and small doses. It seemed to him (Dr. Goldsbrough) that the consecutive effects pointed to the dose. Whether they had to deal with an apparently exhausted state, or an apparently excitable state, indicated the difference in the dose which ought to be given. Dr. Nicholson had suggested doses which were, on the whole, too large in the cases that were indicated. For instance, in the stage of apparent excitement, which was the first observed effect of the drug, one would think that a much higher dilution would act better than the dose Dr. Nicholson had usually used. If this principle were correct it led to the point as to how far one could push the drug in cases where symptoms of exhaustion were apparent. There, it seemed to him, the doses which just came short of inducing a physiological action in the healthy body were the doses which should be used in cases of disease, because they were not likely to get any cases of over-stimulation from the use of them. The doses recommended by writers of the old school were large doses, which must, in their nature, produce symptoms of apparent over-stimulation, and therefore more exhaustion in the end. Those doses, it seemed to him, should be avoided. The question of pathology was a very important subject which had to be considered in the use of strychnine. In cases of disease of the nervous system, where there was a pronounced pathological lesion, one would think that strychnia was contraindicated. It was emphatically in those cases where there was apparently increased or diminished functional activity where strychnia was indicated. In Dr.

Bodman's paper on diphtheritic paralysis there was shown that in this disease there was a distinct pathological change in the spinal cord and in the nerves, and until those changes had subsided the use of strychnine would be contraindicated, or indicated only with the greatest possible caution in its use. The same remarks applied to its use in a great many degenerative diseases of the nervous system. He knew it was popular in the present day to give large doses of strychnine in some forms of paralysis where the pathological state was not known; for example, in general paralysis of the insane, and cases simulating tabes. They should be very guarded in the use of the drug in those states. If they were sure that pathological change had been set up, strychnine would do more harm than good.

Dr. STONHAM thought that in considering the action of strychnine it was best to remember its primary function, *i.e.*, to stimulate the motor centres and the reflex action of the spinal cord. It was in those cases that strychnine was so useful. Cases such as spasm of the muscles, cramps from an undue reflex excitability of the cord, or spasm of the bladder, could be treated with strychnine on homœopathic lines, because they were exactly similar to cases of poisoning by strychnine. But when strychnine was given for exhausted conditions, he thought they got off homœopathic lines altogether. There was not a drug in the pharmacopœia which, if pushed far enough, would not cause exhaustion, and he thought the stage of exhaustion was not to be taken by a homœopathist as an indication for the prescription of the drug. When strychnine was given for cases of exhaustion of the nerves it had to be given in fairly large doses, and decidedly on allopathic lines; it was to gain the primary stimulant action of the drug on the motor centres, and it could not really be considered as a homœopathic action at all. The same was the case when strychnine was injected in cases of operation after collapse for its primary stimulant action on the respiratory centres. Similarly, one would expect it to be useless in cases of hemiplegia, because it was given merely as a stimulant, and not in any sense as a drug which had any curative action.

Dr. CLARKE thought they were too apt to regard the alkaloids as being identical with the drug from which they were derived; but they were really separate entities, and ought to be studied as such. When they had a drug like strychnine, which had been magnificently proved, as it was found in the *Materia Medica*, they were not dependent upon the nux pathogenesis at all for their use of it. He should be inclined to say that Dr. Nicholson was a

somewhat heroic prescriber. He was glad the author brought forward some of his cases, and thought it would be more useful if he had brought forward still more, and had given the crucial indications for his prescription in each case. He was unable to take much stock, as the Americans would say, of the primary and secondary actions of drugs, because he found that if any strongly-marked symptom of a drug was obtained, be it primary or secondary, and the drug corresponded with the case in general particulars, the curative action of the drug would be obtained. If they could get the exact sequence of the symptoms in the case to correspond with the exact symptoms in the proving, they might go as high as they liked, and would cure their case. But it was a very rare thing to be able to get the exact sequence of symptoms, and it was not necessary to do it. An individual symptom could often be analysed, and cases cured, with pieces, as it were, of a symptom. He wished the author had given the differentiating point between the actions of the different salts of strychnine. The salts of alkaloids were rather peculiar in that the acid did not displace an atom of the alkaloid itself, so that they were really different combinations from the same salts of the alkaloids. Dr. Nicholson used the arseniate of strychnine in some cases, and he (Dr. Clarke) wished the particular indications on which that preparation had been prescribed had been given. He had used strychnine a good deal in cases of influenza. The late Dr. Cooper pointed out to him the correspondence between strychnine and a good many cases of influenza, especially in respiratory cases, and he had used it in the sixth attenuation with very good results. There was one important point of homœopathic practice, namely, the knowledge of antidotes. It was often found in patients who came from allopaths that they had been pretty thoroughly poisoned by strychnine. In those cases the necessary remedy was sulphur as an antidote to the strychnine. He had one case especially in mind, that of a lady of about middle life, who had had, under allopathic treatment, some very desperate heart attacks, from which she had apparently recovered by the heroic use of strychnine. The strychnine had been given to the patient over a considerable time. When she came to him she was in a state of rheumatic crippling of almost all the joints, marked by extreme stiffness. That symptom was one of the great indications for strychnine, and the only remedy which did her good was sulphur in a variety of potencies, mostly high. He had mentioned in his Dictionary a case of locomotor ataxy in a man who had been at one time under Sir Felix Semon for laryngeal crises, which

were cured with strychnine. That was a case in which strychnine acted apparently where there was an actual organic spinal disease; the strychnine was exquisitely homœopathic to the case.

Dr. NICHOLSON, in reply to Dr. Clarke, said that personally he had not proved that sulphur was an antidote for strychnine. He could not tell him why he used arseniate of strychnine in particular cases in preference to other preparations, except that when arsenic was indicated in a case as well as strychnine, particularly when there was exhaustion or restlessness, or anæmia, or fever, he thought it was quite proper in such a case to give arseniate of strychnine rather than any other preparation. He thought it was pretty well known, probably for the same reason that Dr. Ord gave iodide of stannum rather than stannum pure, that the salts of strychnine were more soluble in the body than strychnine proper, and an ordinary solution of strychnine was not a very stable preparation. Too much of any preparation of strychnine could be given. If one wanted to continue strychnine for a length of time it was better to give a more soluble salt than strychnine alone, because the small vessels of the kidneys were probably in a state of contraction after the long-continued use of strychnine, and did not excrete in the manner they ought to do. In the same way phosphate of strychnine would be given when phosphorus was indicated by the symptoms of the patient. He did not think there were any reliable provings of the different salts of strychnine to go upon, and therefore one went upon the indications for the two medicines alone. He was interested in what Dr. Clarke said of Dr. Cooper having recommended strychnine for influenza, and that Dr. Clarke had obtained good results with the sixth dilution. He had not seen it recommended for influenza, but in two of the cases he mentioned the symptoms so resembled strychnine poisoning that he believed any dilution of strychnine would have been just as serviceable as the particular form in which he gave it. The facts, to his mind, were very marked. He thought it was rather useless to discuss the three stages; he put them down in that form to connect them with different diseases which suggested those various stages of strychnine symptoms, putting down insomnia and hysteria as suggestive of the very early stages of strychnine poisoning, and the others as suggestive of the later stages. He quite agreed with what Dr. Goldsbrough said with regard to paralysis. When there was a definite lesion it was not very safe to give strychnine, but it might be given for a short time, because if the disease were curable strychnine was just as helpful in its way as electricity.

INDIVIDUALISATION IN THE PRACTICE OF  
MEDICINE.<sup>1</sup>

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As Dr. Burford pointed out in his presidential address at the British Homœopathic Congress held last year, the science of homœopathy owes its existence to the inductive generalisation—like cures like—which Hahnemann first fully established after years of patient experiment and research.

Based upon this broad generalisation, the practice of homœopathy cannot be carried out with reasonable hope of success without the strictest individualisation.

I had intended to confine my attention in this paper to the influence which the personal factor or equation exercises in medical practice, and under this title to include a consideration not only of the individuality of the patient—the element which is generally thought of as exhausting the personal equation in practice—but also of the individuality of the physician, upon which more depends than is generally supposed. But I found that the individuality of patient and of physician did not by any means represent the full quota of doubt and of uncertainty to which the personal factor might be said to give rise, and that to adequately analyse the part played by this variant we must include within the scope of our enquiry the individuality of remedies, the due appreciation of which forms probably the most important part of the physician's equipment. In this way the consideration of the purely personal factor as exhibited in the patient, and by the physician, became submerged in that of the wider problem of individualisation in the practice of medicine.

It is, I think, the peculiar merit of the homœopathic philosophy of cure that it supplies us with the means by which we can analyse and differentiate to the fullest possible

<sup>1</sup> Presented to the Liverpool Branch, November 10, 1904.



extent not only the phenomena of sickness, but also the remedial powers of drugs. Individualisation has become one of the fine arts, and in practice affords us benefits second only in importance to those afforded by our therapeutic rule, *similia similibus curantur*.

Let us consider it first in its relation to drugs and drug action.

The homœopathic materia medica, unlike that of the orthodox or any other school, is composed of the records of numberless experiments made upon healthy individuals with drugs, administered singly, *ad hoc*, and with every possible precaution as to purity. The results of these experiments, coupled with the data, symptomatic and pathological, which the records of poisonings afford, together constitute our equipment. The experiments have shown that each drug, when duly administered, is capable of producing its own peculiar symptoms in varying degrees, depending in part upon the dose of the drug given and in part upon the susceptibility of the individual prover. Apart, however, from the divergences which these two causes necessarily produce in the records of provings, there is an underlying unity of expression in the results obtained from each drug which is quite unmistakable, whilst, as regards poisonings, the uniformity of the results is even more strikingly apparent; and it is interesting to note how fully the objective gross pathological symptoms of the toxicology of a drug confirm the indications of subjective and functional disorder which its proving affords.

It was only after many years spent in patiently testing drugs, one after another, on himself, his family and his friends, that Hahnemann was able to formulate his theory of the dynamic or specific action of drugs on the human body. His aphorism (*Organon*, § 111) runs as follows:—

“The agreement of my observations on the pure effects of medicines with these older ones—although they were recorded without reference to any therapeutic object—and the very concordance of these accounts with others of the same kind by different authors, must easily convince us that medicinal substances act in the morbid changes they produce



in the healthy human body according to fixed eternal laws of Nature, and by virtue of these are enabled to produce certain reliable disease symptoms, each according to its own peculiar character."

This generalisation, like that of *similia similibus curantur*, is capable of experimental verification, and is, as a matter of fact, so constantly verified in our experience that it has become axiomatic amongst us and is one of the cardinal beliefs in the homœopathic philosophy. And it is fortunate that it lends itself so completely to experimental verification, because the premises—if they may be so called—upon which the theoretical explanation of this practical truth is based are not such as to command instant acceptance in all quarters. Most men would, I believe, be prepared to accept the statement that every drug possesses a disease-producing property, *sui generis*, but not every one would be satisfied to accept the other Hahnemannian premise, that such disease-producing power acts, in the proving, through the medium of the vital force of the prover.

That the same drug, provided it has been prepared in exactly the same way and, in the case of a plant, grown under similar conditions of soil and gathered at the same stage of its growth and development, must possess, under such circumstances, properties physical, chemical and pathogenic, uniform both in kind and in degree, is a proposition both biologically and physiologically sound. It is, however, very different with regard to the latter premise. Vital force is an unknown and, but for its effects, an unknowable and also a very variable quantity, and as such has given rise to much controversy amongst us. There are many amongst us who would like to see it wiped off the slate and to substitute in its place something non-committal in character, which would help to bridge over the gulf between us and the more materialistically minded orthodox school. I believe that to do so would be to sacrifice our birthright for a mess of pottage.

In this connection I may quote an extract from "Hudson's Laws of Mental Therapeutics," bearing upon this point and summarising the opinion current in scientific

circles concerning it. After quoting from Binet's work on "The Psychic Life of Micro-organisms," Hudson goes on to say: "The salient point to be observed here is that so far as the physical sciences reveal the structure of man he is composed wholly of confederated cells, each one of which has been developed and perfected with special reference to its place in the organism and the function assigned to it.

"Nor must it be forgotten that each individual cell is a mind organism and that it is endowed with an intelligence commensurate with the duties it has to perform. . . . Nor will any intelligent physician, surgeon, or biologist, gainsay the proposition that the mind organisms are governed, controlled, and directed in their work by a central intelligence resident within the organism. Scientists may differ as to the proper terminology by which the central intelligence should be designated; but no one denies its existence or its power to control its millions of subordinates. Thus it has been called 'the subconscious mind,' the 'subliminal consciousness,' the 'secondary self,' the 'unconscious mind,' the 'communal soul,' the 'secondary personality,' &c., the various terms employed being largely governed by the point of view from which the subject is treated. I have designated it as the 'subjective mind' for reasons which have already been stated.

"Philosophers may differ in opinion as to its origin and ultimate destiny; the biologists may not be agreed as to just what it is—that is to say, whether it is the sum of all the intelligences of which the body is composed, or whether it is an independent entity capable of surviving the dissolution of the confederacy over which it presides. None of these questions are at issue in this discussion; for the one salient fact upon which all who are acquainted with the propædeutics of experimental psychology are agreed is that it exists, that it is an intelligence, and that it controls the organisms of all sentient creatures. Even Haeckel, the great materialist who apparently knows nothing of the new psychology, has this to say of what he calls the 'tissue soul': 'This "tissue soul" is the higher psychological function which gives physiological individuality to the compound

multicellular organism as a true "cell commonwealth." It controls all the separate "cell-souls" of the social cells—the mutually dependent "citizens" which constitute the community.' "

The belief in the existence and paramount importance of this vital force is an absolutely essential part of the Hahnemannian philosophy, and I was greatly pleased to discover, in this unexpected quarter, so able and up-to-date an apologist. It is this vital force which, in the case both of provings and of natural diseases, causes each person to be a law unto him and herself. We find in every-day practice that exposure of numbers of people to the same morbid, even the same infective, agent is followed by about as great a variety of sick manifestations as there are people involved; in like manner we find that in provings reaction takes place, so to speak, at different levels and with corresponding differences in the effects produced. It follows as a natural corollary that, in order to ascertain the full range of symptoms which a drug is capable of producing, we require the service of as many provers, male and female, as it is possible to have, and to properly record and classify the results. But great precautions must be taken both before and during the conduct of a proving, so as to establish beyond doubt the validity of the view that the symptoms produced do represent genuine medicinal action. Of these precautions the most indispensable is that the prover be, if not ideally healthy, at least free from signs of evident and active disease. This condition is laid down by Hahnemann in the most definite possible language (*Organon*, §§ 121, 126), yet there are unfortunately quite a number of instances in which it has been violated. Take, as an instance, the records of aconite contained in "*Allen's Materia Medica*." On reference to the authorities quoted, we find that the experiments of at least three observers were made upon people suffering from various diseases, ranging from "dementia" and "epilepsy" to "sciatica" and "a considerable swelling in the left iliac region."

The defence which I have seen brought forward for this

indiscriminate selection of cases cannot, it seems to me, be sustained. It is said that by taking the symptoms of the person to be experimented upon, from day to day, for some time prior to the institution of the experiment, you can obtain the mean of the diseased condition symptoms, and that the changes in that mean which occur subsequent to the taking of the drug must represent the drug action. No one who realises the complexity and the changeableness which characterise most diseases can venture to accept such an argument.

The regulations which Hahnemann lays down for the guidance of the prover are so typical of his genius that I cannot refrain from quoting them :—

“ During all the time the experiment lasts, the diet must be strictly regulated ; it should be as much as possible destitute of spices, of a purely nutritious and simple character, green vegetables, roots, and all salads and herb soups should be avoided. The drinks are to be those usually partaken of, as little stimulating as possible.

“ The person who is proving the medicine must during the whole time of the experiment avoid all over-exertion of mind and body, all sorts of dissipation and disturbing passions ; he should have no urgent business to distract his attention, he must devote himself to careful self-observation and not be distracted whilst so engaged ; his body must be in what is for him a good state of health, and he must possess a sufficient amount of intelligence to be able to express and describe his sensations in accurate terms.”

This code of instructions shows better than anything else could do the very grave sense of responsibility with which Hahnemann entered on his labours, and his rigid observance of the code shows how fraught his whole being was with the desire to add to the common welfare of the race.

We now come to the consideration of the homœopathic materia medica, so obtained, and the question we have to ask is how we are to study these provings so as to learn to individualise the drugs. Is it possible to glean from out the mass of confused and disjointed data symptoms, or a series

of symptoms, which may be looked upon as distinctive attributes of each drug, and, further, in what sphere or plane of consciousness of mind or of body may we expect to derive most efficient aid in so doing?

It seems to me that for such a purpose the gross pathological changes recorded in the *materia medica* cannot be relied upon. This class of evidence must, I think, be ruled out of court, if for no other reason than that it can only be obtained, or, perhaps I ought to say, verified as obtaining, in poisonings—and poisonings, though a useful constituent part of our *materia medica*, are relatively few in number. In other words, to set up the gross pathological standard as the means of individualising the drugs would mean the annihilation of practically all the provings obtained from moderate dosage, seeing that no prover is prepared to so far immolate himself, or is likely to be prepared to carry the experiment sufficiently far to enable us, even with the greatly improved instruments of precision which now exist, to detect gross pathological changes in his organs. The pathological standard seems to me not only an impractical, but also an illogical, one: impractical, unless experiments upon animals, which, in my opinion, ought not to be tolerated, are allowed, and illogical, as illogical in every respect as it would be to deny the power of electricity to kill because in small doses it produces stimulation only.

Setting aside pathology as by itself an inefficient and unreliable index of the potentialities of a drug, *i.e.*, of a drug's individuality, let us review our symptomatology from another standpoint.

There are to be found in the provings of every drug symptoms such as vertigo, headache, nausea, which cannot possibly be regarded as distinctive, seeing that they have been produced over and over again by numberless drugs. Such symptoms are known as "common" symptoms. But occasionally we find some qualification attached to such "common" symptoms, *e.g.*, nausea at sight or smell of food, vertigo by running water, headache as if a ball were beating against the skull. Such qualifications, concomitants of symptoms, help to individualise from out the run

of common symptoms, those to which we find them attached, and are, or may be, of very great importance—may even suffice to put the stamp of individuality upon a drug by converting the otherwise common symptom into one peculiar to, and therefore characteristic of, one drug alone.

Again, we may notice in studying the pathogenesis that drugs are to be found here and there which affect the whole economy of the prover to the production of a certain type of pain. Take, for example, the pains of arsenic, which are characteristically burning, of kali carb., stitching, of lachesis, pulsating hammering, and of nitric acid, pricking as from splinters. I do not mean that such pains are the only ones produced by these drugs, but that the relative frequency of those specified over any other kind of pain recorded is so marked that they become more or less indissolubly associated in our minds with these particular drugs. The symptoms which pervade the whole economy are known as “generals,” and the establishment of these “generals” enables us in a measure to fill up the gap caused by the natural limitations of provings. It enables us to utilise the drugs in conditions where the characteristic pain is present, even though the record of the proving may not contain an instance of the pain having been produced in the particular site complained of.

Another and a very efficient means of individualising drugs is afforded us in the conditions of amelioration and of aggravation, which, in accordance with the instructions laid down by Hahnemann (*Organon*, § 133), have been very fully wrought out in the provings.

In like manner the periodicity which characterises the action of many drugs occasionally supplies the necessary means by which to distinguish them, similar though it may be in most other respects, from one another.

In my view, however, the mental and the moral symptoms form, when fully elicited, by far the most important individualising features. It is in this province that homœopathy, or rather the special system of careful drug provings which homœopathy was the means of introducing, has won its most enduring laurels, as it enables us to observe, and subsequently to utilise, all such subjective and otherwise

unattainable drug indications. As illustrating this class of symptoms we may instance the religiously inclined and philosophic attitude and sulphur, irritability and crossness and the appropriate drugs, chamomilla, the mentally deficient and obtuse state and baryta carb., and precocity and excitability and belladonna. These and many more, which will readily occur to the mind, are brought out in the provings in so characteristic a manner as to become almost inseparably associated with the drugs mentioned.

Before leaving this part of my subject I should like to refer to another aspect of symptomatology which has been much discussed, viz., the relative values of the symptoms in each individual proving. Some are inclined to approach this question in what may be called a mathematical spirit, and to say that symptoms should be graded in order of value in accordance with the number of the provers in whom they have been elicited—that the symptoms produced in every prover ought to rank first in value, and that those got in one-half, in one-third, &c., of the provers should be rated proportionally. In one sense, *i.e.*, when considered only in relation to the drug, this means of estimation seems quite a correct one. But to my mind, when we take into consideration the co-efficient of the prover, the numerical basis of computation falls far short of our proper standard. The advocates of the numerical basis hold, and from this standpoint hold with perfect right, that symptoms only recorded by one or two out of perhaps forty or more provers ought to be ignored as being practically of no value. Against such a process of expurgation I would protest, as it seems calculated to imperil the peculiar heritage of homœopathy, viz., the ability to individualise drugs according to the principles I have suggested.

We pass now to the consideration of the latter part of our subject, viz., the individualisation of the patient. From the tenor of the foregoing remarks you will doubtless have gathered my views upon this problem, so that I need not detain you long over it. First, then, and foremost, I believe in Hahnemann's dictum that all the symptoms, subjective and objective, together constitute the disease—we are dealing



with patients, not with nosological entities—and we must therefore, in attempting to individualise or to diagnose, include in our survey the whole man. Our relation to pathology has formed a fruitful source of discussion for many years. I believe that if we were more imbued with Hahnemann's conception of disease as disordered vital force, we might very well afford to leave the controversy alone, seeing that in the light of that conception every symptom is itself pathology, and conversely, that every pathology has its own symptomatology, which, could we but read it aright, affords us not only an indication of the morbid change that is taking place, but acts as a guide to cure, if cure be possible. So then, as in the case of the drug provings, and on precisely similar grounds, I do not regard pathology as affording a suitable means of individualising patients. There is one and only one way of individualising our patients, and that is to take the totality of the symptoms. To take the case thus, *more Hahnemanni* is no easy task, but with the inspiration and the enlightenment which a study of the *materia medica* affords, it becomes gradually easier.

Kent somewhere throws out the suggestion that when provings have been made of all the drugs with which we are provided in Nature, the records we should have would present a portrait of all the kinds and sorts of ailments possible to be met with in the race. Certainly the degree in which our pathogenesis has already advanced our clinical understanding of natural disease would appear to warrant the suggestion. We appreciate now and in a way we never could have done before we were informed by our knowledge of the pathogenesis that in rheumatic affections some patients evidence uncontrollable restlessness, whilst others resist the slightest, even passive, movement: that in catarrhal conditions some people get freedom and relief indoors, and others only out of doors: that eating and sleeping, lying down and rising up—any or all of these most ordinary proceedings—may be discriminating features of the diseased condition: that the whole range of modalities, concomitants, general and common symptoms, found in such abundance in our *materia medica*, are to be found in operation in diseased



conditions, and we instinctively use them in our every-day practice as aids to individualisation. But the only legitimate basis of the practice of homœopathy is the clear recognition of the totality of the symptoms as constituting the "case" and affording us the only safe and reliable rule for the individualisation of our patients.

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### TRIBUTES TO DR. DUDGEON.

At the opening of the present session of the British Homœopathic Society, its Fellows and members were sustaining an immediate sorrow in the loss of one of almost the original members, Dr. Robert Ellis Dudgeon. Dudgeon was elected a member of the Society in 1847. He was Secretary in 1848. He was Vice-President in 1874-75. On the death of Dr. Quin, who had held the office of President from the date of the foundation of the Society in 1844 until 1878, Dudgeon was elected President. After the year 1878 Presidents were elected annually, and Dudgeon was chosen again in the year 1890. He had also been Treasurer from 1883 to 1893, and occupied a seat on the Council in 1893 and 1895. He had been a very regular attendant at the meetings of the Society, and, as past volumes of the Annals and the Journal testify, he almost always took part in the discussions, sustaining the interest of the meetings by his insight, contributions of facts, and criticisms of the subjects in hand. The first meeting of the current session, held in October, was the first meeting of the Society after Dudgeon's death. This meeting is usually occupied in the delivery of an address by the President for the year. On the present occasion it was felt by the President, and, as indicated below, his feeling was supported by the assembled Fellows and members, that the address should be postponed, and the meeting devoted to expressions of appreciation of Dudgeon, his personality and work, and the sense of loss that was felt in his absence, and that he would no longer be a familiar figure at the meetings of the Society.

In response to an invitation of the President to members present to express their sentiments

Dr. BLACKLEY rose and said: Gentlemen, my recollection of Dr. Dudgeon goes back over a good many years. I realise, as must all realise, how insufficient words are to express all we feel

on occasions like the present. I have said, on occasion, in this very room, "We love him!" Alas, we must now say, "How we loved him!" "*De mortuis nil nisi bonum*" is frequently said, but how rarely it happens that we are able to challenge the world to say anything but good of one who has just left us; in the case of Dudgeon, however, we may do this with calm confidence, for he had not an enemy.

My remembrance of Dudgeon goes back to that time when, in 1869, he joined the staff of the Hospital as assistant physician, at the same time that Madden was appointed physician and Bayes assistant physician. It was characteristic of Dudgeon's modesty that he accepted the post of assistant physician at the same time that his old fellow-student in Edinburgh and Vienna was appointed to the superior post; both Dudgeon and Bayes went downstairs to the out-patients' department and did splendid work there. Unfortunately for the Hospital, Dudgeon did not remain very long there; not sufficiently long, in fact, to succeed Madden when the latter was incapacitated from work by illness. Dudgeon resigned his post for reasons which need not be entered into, but which were connected with the question of staff representation on the Board. Suffice it to say that his resignation, and that of Bayes, which took place at the same time, were a serious and lasting loss to the Hospital. At the bedside Dudgeon did not perhaps shine as a consultant; he was no courtier; he was much too honest, in fact, to be a fashionable consultant; but from my experience of him in consultation I can say that one rarely failed to get substantial help in diagnosis and many valuable hints as to the choice of remedies, the latter being the fruit of his intimate knowledge of drug diseases. Coming down to later times, which are in the recollection of all but the very youngest members of the Society, one cannot help but look at the imposing list of works which Dudgeon translated from the German, and which now form, in fact, our most valuable armamentarium — Hahnemann's "Organon," his "Lesser Writings," his "Materia Medica Pura," his "Therapeutic Hints," and last, but not least, almost the whole of the German work in the "Cyclopædia of Drug Pathogenesis." We know full well that without Dudgeon and Hughes the Cyclopædia would never have existed. With a nature somewhat combative, it was absolutely impossible that Dudgeon should not occasionally take up the cudgels for things concerning which much difference of opinion existed. For instance, I did not see eye to eye with him in the matter of the Homœopathic League Tracts; and when discussing the subject together often

reminded him of an incident which took place in the very year that he was appointed to the Hospital. At a dinner at the Freemasons' Tavern in aid of the Hospital funds, Dudgeon was called upon to respond for the toast of "Homœopathic Literature," and made an interesting, but exceedingly modest, speech; but the thing which impressed me most of all was his peroration in which he said "*I have always written for the profession!*" Of Dudgeon's kindness to beginners I have no doubt we could all say a good deal, and if time allowed I could do the same. One little incident I must mention. By a strange coincidence a patient came to see me to-day to whom many years ago, when quite a beginner in practice, I took Dudgeon in consultation. The man got well in time and was exceedingly grateful. About three months afterwards his wife, who had never been to me as a patient, fell ill, and drove round to 43, Montague Square, and asked for an appointment with Dr. Dudgeon, which he gave. On seeing the lady, however, he said, "What do you want?" She said, "I want to consult you." "Oh, but," he said, "there is Dr. Blackley. You go to Dr. Blackley. If he is in any difficulty I will be delighted to meet him, but I cannot see you." Such incidents as this sink deep into the memory, and are very sweet to dwell upon long years afterwards. I thank you, gentlemen, for allowing me to say these few very imperfect words in reminiscence of a great and good man.

Dr. MADDEN thought he might claim to have had a longer personal acquaintance with Dr. Dudgeon than anybody in the room. He was only a small boy when he first made Dr. Dudgeon's acquaintance, who was a very great friend of his father, the late Dr. Madden. They were at Edinburgh University together, they qualified for their degree in the same year, but as Dudgeon was two years too young to take it, he put in those two years studying abroad until he could do so. Probably that two years difference in seniority accounted for Dudgeon accepting the junior post to his father when they were appointed on the Hospital staff. Later on, after Drysdale had persuaded Dudgeon to look favourably on homœopathy, his (Dr. Madden's) father and Dudgeon went to Vienna together and studied under the celebrated Fleishmann. From that time their friendship never flagged till his father's death. Dudgeon was, as everyone knew, a most genial man, and could find something amusing and interesting in every topic. With regard to his professional abilities and the work he did for the advancement of homœopathy, he thought none present would feel aggrieved

if he said there was no one now living who had done half, and few a quarter, as much as he did for the advancement of homœopathy. Not only did he, with his own hand, put into their mother tongue the chief writings of their master, but he worked hard at his professional work and made his name known throughout the whole medical world by his invention of the pocket sphygmograph, and his name being honourably known in connection with that invention threw reflected glory on the body to which he belonged. He made his name known in various other directions. Although they might differ as to the desirability of propagandism amongst the laity, there was no question about it that the work he did in regard to the Homœopathic League Tracts was practically the whole of the work that was done. Out of something like forty tracts he wrote thirty-eight; and anyone who had read them knew that every one of them was worth reading. One of the most useful things, in thinking of the life of their friend, was that it should make them feel how little they had done in comparison with what he did, and his work should make them try, now that he was gone, to do more than they had done up to the present, in order that they might favour the cause he had so much at heart.

Dr. BURFORD said: "The angel of death has been abroad in the land; we can almost feel the beating of his wings." With those words that great tribune, John Bright, electrified the House of Commons many years ago on the death of a great personage, and with those words he heralded his appreciation of the distinguished colleague who had just passed from them. A great man had been among them, and they were met that evening to do homage to his memory. They were not assembled to bury Cæsar, but to praise him—each to pay their individual tribute to the virile personality which had impressed itself so long and so powerfully on their great cause. They had all too recently lost a succession of master spirits, men under whose impetus homœopathy had grown to its present condition of importance. Now they had to add to this list of immortals, Dudgeon. In many respects the last was the greatest. One was forcibly reminded in thinking of Dr. Dudgeon of the famous saying of Gibbon about Burke, that you could not take casual shelter from a rain-storm for a quarter of an hour in his company without saying, as you came away, "That is a remarkable man." They were fascinated by their colleague's great intellectual gifts no less than by the geniality and sweetness of his character, and his ready accessibility to all. He very well remembered his first introduction to

Dr. Dudgeon; he was then smarting under his exclusion from the fellowship of the Obstetrical Society, a penalty he paid for embracing homœopathy, and he went with Dr. Clarke one evening to pour out his story to Dr. Dudgeon and seek his advice. He remembered the sympathy and patience with which Dudgeon listened to his personal narrative, the very kindly suggestions he made, and the assistance that he proffered. They honoured their great colleague no less for his great intellectual gifts, for the sweetness and charm of his personality, than for his intense love of justice and passion for liberty. They would all recall when the case of Dr. Theobald was under the consideration of the Society how ardently Dudgeon lent himself to the repressing of what seemed to him a wrong, with what contempt and scorn he spoke of the attempt to suppress freedom of thought. It would be difficult in any brief retrospect to do justice to the many-sided character of the great man who had passed away. Age could not wither, nor custom stale his infinite variety, and they were conscious that they had had among them a prince among men. They did not require storied urn or animated bust to remind them of Dudgeon's life-work; all over the world, wherever there was a well-stocked homœopathic library, *si monumentum requiris circumspice*. No words of his could express the full-orbed personality of that indomitable champion. It required the touch of genius to do it, and the touch of genius had accordingly effected it. A former poet laureate had sketched for us a similar career. There was the generous spirit which illumined the daily round; there was the thirst for knowledge, which was a natural instinct; there was the sensitive being, alive to the cry of human pain; there was the doer of righteousness, the champion fierce in battle; the lover of simple pleasures; there was appreciation of honours, yet carelessness of them; an aspiration ever to a higher life; and the poet finally sums up:

This is the happy warrior: this is he  
Whom every man at arms would wish to be.

And no better type of the "happy warrior" could be found than Dr. Dudgeon.

Dr. Burford then submitted to the Society the following resolution: "That this Society record on its Minutes the profound sorrow of its members at the death of Dr. Dudgeon, one of its founders, and throughout one of its most distinguished members. It further desires to place on record its appreciation of the splendid services rendered to homœopathy by this brilliantly gifted colleague, and of the nobility and sweetness of

his character. Also, to mark its sense of the honour due to his memory, that this Society do adjourn its business until the next ordinary meeting."

Dr. CLARKE seconded the resolution. He said that it was quite impossible in words to give the measure of the man who had just left them. No greater man had been seen amongst homœopathists since homœopathy came to the country. And the one who was least conscious of his greatness and his worth was Dudgeon himself. The fact that he never knew his own greatness, whilst it was in some ways one of his greatest charms, was somewhat of a loss to homœopathy. If the power and the bigness of Dudgeon had made proper impression on the world, it would have reflected much more greatly on the community of homœopathists than it actually did. His acquaintance with Dr. Dudgeon went back to the period at which he (Dr. Clarke) was house surgeon at the Hospital, when he met him at the Society's meetings. He became more intimately associated with him during the last two years of the life of the *British Journal of Homœopathy*, during which period, at Dr. Dudgeon's request, he had joined the editorial staff of that journal. Later on, when the *British Journal of Homœopathy* came to its glorious end, he (Dr. Clarke) took over the editorship of the *Homœopathic World*, and from that time Dr. Dudgeon gave him his heartiest help in editing and contributing to the pages of that journal. He also gave him help, which was of very great importance, in compiling the index. Dr. Dudgeon's greatness could not be confined to his work in homœopathy, vast as that was. His translation of the "Organon," and of the "Materia Medica Pura," would always be the standard translations for English-speaking peoples. His love of index-making led him to give the greatest help in the compiling of the "Cypher Repertory," which Drysdale, Russell, and others were promoting. His particular part of the "Cypher Repertory"—the section of Mind—was the part which was of the greatest value to those who had not mastered the Cypher. Dudgeon had the faculty of arrangement, a very rare faculty, which homœopaths above all needed on account of the enormous amount of detail which was involved in their work. It was true that the first part of Dudgeon's work was written entirely for the profession, but there came a time in his life when he saw that the profession was not open to receive the works that were written for it; he perceived that direct appeals to the profession were, for the most part, thrown away, and he came to the conclusion that if homœopathy was to make progress, direct appeals to the public must be made.



Thereupon he made his direct appeals to the public in the Homœopathic League Tracts, which were the standard appeals at the present day, and would be for many a day to come. They were magnificent works of their kind, solid, and to the point, as all Dudgeon's works were. Dudgeon was great in many ways. He was a great literary man as well as a great homœopath, but above all he was a great man. His geniality and his great-heartedness had been important factors in the building up of homœopathy as it was to-day. Around his hospitable table had gathered at some time or another almost all, not merely British but foreign homœopathists who had visited this country. Dudgeon used to call himself a foreigner in London by virtue of his Scottish birth, and he was quite at home with foreigners of every description who could speak either French or German. The Society could never be the same now that it had lost Dudgeon's personality, his geniality, his absolute honesty and straightforwardness, which they all loved, and which they would never see again.

Dr. DYCE BROWN, in supporting the resolution, said that while they were sad at having lost their distinguished colleague, there was a great amount of satisfaction in looking back at his life. He lived to a grand old age, long past three score years and ten, and lived an active, strenuous life up to the very last. Although they knew from his age that the end could not be very long delayed, yet, as they saw him constantly at the meetings, that side of his life did not occur to them, so that when the end did come it came with a shock. Dr. Dudgeon's genial presence was always welcome, and his remarks and observations were exceedingly valuable. With his strong character, always so straight and courageous in doing what he knew was right, he had that charming geniality of temperament which made him beloved by all. There was no member of the homœopathic body who was so respected by the old school as Dudgeon; he was respected more than any other homœopathist that had ever lived in England. They must look back at his life as an object-lesson for them, and the lesson he had taught by his life was—"work while yet it is day; the night cometh when no man can work." He had received the following letter from their venerable colleague, Dr. A. C. Clifton, who unfortunately was unable to come to the meeting owing to illness :—

"DEAR DR. BROWN,—Until a fortnight ago I quite anticipated the pleasure of meeting my old comrades again, to congratulate our President, and especially to join with others in rendering a

tribute of respect to our dear departed friend and our condolences to his surviving relatives.

“ Unfortunately I have been confined to bed for the last fortnight and am still there, for which reason I shall not be able to carry out my original intention—a *bitter* disappointment to me.

“ Had it been otherwise I would have told that while my first acquaintance with Dr. Dudgeon was in 1850, at the Cheltenham Congress, it was not till somewhat later that I became intimately acquainted with him. Since which time we have (so to speak) travelled hand in hand together, I ever looking up to his face for encouragement and hope, which never failed me. I could say a great deal about him as to his goodness, but must refrain.

“ Needs there the praise of the love-written record ;  
The name and the epitaph graved on the stone ?  
The things that he lived for, let them be the story.  
He himself be remembered by what he has done.

“ The words of another poet are very appropriate for such an occasion :—

“ Better a death when life's work is done  
Than earth's most favoured birth ;  
Better a child in God's great house  
Than king of all the earth.

“ Believe me, with love to all the brethren,

“ Yours sincerely,

“ A. C. CLIFTON.”

Dr. H. NANKIVELL said the present occasion brought to his recollection that on which he occupied the chair last year, and reminded him of the manner in which allusions to the age and honour which Dr. Dudgeon brought to them were received by members of the Society. In 1865, when he began the study of homœopathy at Liverpool, there were names which the younger men looked up to as the bright constellation who formed their leaders at the time, such as Dr. Drysdale, of Liverpool, and his friends Dr. Dudgeon, Dr. Black, Dr. Ker and Dr. Madden. Those men had all passed away ; they were all remarkable men, but Dr. Dudgeon, Dr. Drysdale and Dr. Madden were the three principal stars in that glorious constellation.

Dr. W. ROCHE said that his first thought when he saw the notice abroad of their late colleague's death was, “ How we shall miss him ! ” It seemed to him that the chair in which Dr. Dudgeon sat should, as it were, always be preserved, in order that they



might get, what perhaps would be the best outcome of his life, something of inspiration from the grand, persistent, wonderfully successful work which he accomplished among them. He did not feel sure that Dr. Dudgeon was not there that evening. He was one of those who believed that a very narrow line separated between the things that are seen and the things that are unseen, and he felt thankful that so much that was meet indeed should have been said about their departed comrade. It seemed to him that in days gone by the whole of the meeting felt better for seeing Dr. Dudgeon present, and in spite of his increasing infirmities, to hear him talk, to notice how kindly his remarks were, always acknowledging in his own inimitably gracious way the efforts that even the youngest member might make, and how he showed that, although he was getting very advanced in years, his mind and intelligence were at the disposal of the Society, and anything and everything he could say and do were continuously done. It was a grand life and a beautiful death. The end came very gently and peacefully. Young in all that made life beautiful, never having the feeling, or looking at all, as it were, the old man—for he was always blessed with the eternal spirit of youth—he passed away most gently at the end, preserving his intellect to the very last. What a lovely death after a strenuous and yet most earnestly useful life. Strangely enough, that morning, when he (Dr. Roche) was thinking about the evening's meeting, there came to his mind that beautiful line from the "In Memoriam":

God's finger touched him, and he slept.

Dudgeon's place was empty, and with their eyes they would see him there no more; but something would come from what had been said and from the memories that had been aroused in thinking of their colleague that evening. Dr. Roche did not know whether any of the members had read a very remarkable article which appeared in the *Times* about the Japanese nation, entitled "The Soul of a Nation." A quality was spoken of there by the strange name of Bushido, a sort of lofty national instinct; and he hoped that something of that kind would come out of all that had been said, and which had been in their thoughts that evening. If they could not hope that the power of their departed friend might rest upon them, something of his endeavours might be theirs; they might carry on, which would be the best and highest tribute to his memory, in some degree, each of them according to his ability, the good work for which he fought so nobly and so long.

Dr. GOLDSBROUGH said he wished particularly to re-echo the sentiments which Dr. Roche had just spoken ; they expressed his feeling about Dr. Dudgeon as well as anything that had been said. He (Dr. Goldsbrough) had two or three very interesting reminiscences of Dr. Dudgeon's personality. As they all knew, he was accustomed to speak first in the discussions at the Society. The first time he (Dr. Goldsbrough) had the temerity to stand up and read a paper at the meetings, it was with great trepidation and fear of what the scions of homœopathy would say. Dr. Dudgeon, as usual, opened the discussion, and gave him just the note of encouragement that a youngster needed, by saying, "If this is done in the green tree, what will be done in the dry?" He (Dr. Goldsbrough) felt like a disciple of such a pioneer of homœopathy. His first acquaintance with homœopathy in his professional life was in association with the school founded by Dr. Bayes and others. Speaking from hearsay, and after reading some of the correspondence, he believed that Dr. Dudgeon was not always in agreement with the founders of that effort. He remembered the late Mr. Harris telling him of four men, all honoured by them, Drysdale, Dudgeon, Ker and Black, who were called the Scotch quadrilateral. These four men severely criticised the proposed methods of the school. He did not think any offence would be caused if he used that term now as including Dudgeon, because it was to Dudgeon's honour that he thoroughly criticised every proposal which was put forward for the benefit of homœopathy ; he criticised it down to the ground, with a view to its development. That was a feature of his action in reference to homœopathy ; if they looked through his work it would be found that that principle ran through it all. Again, Dudgeon tried to emphasise the maxims of experience in homœopathy in preference to the speculative or hypothetical side. This was well illustrated in the discussion on the dose question some two years ago, when it was brought up at the Society. There was nothing of the drooping gait about Dudgeon's personality. He (Dr. Goldsbrough) only knew him in the third generation of his life ; he was fifty-eight on a first acquaintance, and he died at eighty-five. During that long period they saw nothing of failure, which suggested that he believed in the permanence of even this present life, and that was a note which he struck only a year or two ago. As far as he knew he was going to live on for ever. That was a splendid thought for those who had to contend with disease and try to restore the sick back to health. Shakespeare had used a remarkable phrase about old age. Referring to

one of his characters he said: "He took the instant at the forward top," *i.e.*, he was always ready to make the best use of the time in front of everybody else, which gave them a splendid example. He (the speaker) thought, with Dr. Roche, that there was a great responsibility laid upon those who might be presumed to be in the prime of their days, that if homœopathy was to be devolved they must work hard, because the workers of the past had had to lay down their work. He only hoped that, for himself, he might be able to carry out that sentiment, and so try to build a monument to those who had gone.

Dr. JAGIELSKI said he had always had a great admiration for Dr. Dudgeon from the moment he knew him. He was not only a very honest, kind, considerate and generous colleague and friend, but he was particularly distinguished for his literary work and his geniality. He (Dr. Jagielski) particularly remembered Dr. Dudgeon's kindness in the interest he took in the fight which took place at the Margaret Street Infirmary for Consumption and Diseases of the Chest between the homœopathic as against the allopathic medical staff. The homœopaths were called upon by the Executive Committee to resign or to desist from their homœopathic treatment at that Infirmary, to remove their names from the homœopathic directory, and to give up any appointments they might hold at any homœopathic institution. The Executive Committee did not consider that such homœopathic practice was conducive to the true interests of the Infirmary, and was entirely contrary to the practice hitherto pursued in it. Dr. Dudgeon, who had, as a subscriber to the infirmary, become a governor with voting power, called attention at the annual general meeting, when Lord Grimthorpe was voted into the chair, to this irregularity, and to what he considered an improper proceeding on the part of the Executive Committee and the allopathic members of the Medical Committee and Staff. Dr. Dudgeon's amendment, "That any attempt to limit the liberty of opinion or practice of medical officer was not sanctioned by the laws of the Infirmary, was prejudicial to the interests of the Infirmary and its patients, and was opposed to the spirit of the Medical Act of 1858," was brought forward, duly seconded, and carried by a majority of governors. Thus, Dr. Jagielski stated, after several adjourned special general meetings and prolonged discussions, the advocates for liberty of medical opinion and practice gained decisive victories over the partisans of exclusiveness, and of the suppression of liberty of opinion in medical matters, due to Dr. Dudgeon's influence. This happened in 1887, and when in

1896 there was a revival of the same animosity by the new medical staff's executive committee, this fight, too, ended in a similar victory.

The following letter was sent to the President by Dr. J. W. HAYWARD, of Birkenhead :—

“ 61 Shrewsbury Road, Birkenhead,  
“ October 5, 1904.

“ DEAR DR. JOHNSTONE,—I cannot find words to express my feelings about our venerable colleague and mentor, Dr. Dudgeon, or the sense of loss and vacancy that hangs over me since he is no more amongst us. His straightforward, bold honesty, his wonderful scientific insight and grasp, his wide and accurate professional knowledge and ability, and his power to expound and defend the truth in medicine ever commanded my admiration and reverence. I felt him to be one of the greatest of Hahnemann's followers and expounders. In his presence I always felt as if almost in the presence of Hahnemann himself; and his writings have been to me essential food. Alas, for homœopathy !

“ I have also often felt that had he not avowed his belief in homœopathy he would long ago have been President of the College of Physicians and bedecked with all the honours the profession had to bestow.

“ When may we see his like again ?

“ Yours truly,

“ JOHN W. HAYWARD.”

Dr. PROCTOR telegraphed as follows : “ Would express the feeling that Dudgeon deserves the royal title of Defender of the Faith—*Dei gratia*.”

Dr. Burford's resolution was carried in solemn silence, all the members present rising in their places.

Dr. DYCE BROWN then moved that the President and Secretary be requested to communicate to the relatives of the late Dr. Dudgeon the condolences of the Society in their sad loss.

Dr. CLARKE seconded the motion, and suggested that a copy of the resolution which had just been passed should also be forwarded.

Dr. BYRES MOIR, in supporting this resolution, said there were three things which had particularly struck him in regard to their old colleague. Firstly, the full amount of work he did. Anybody looking at the number of books he had translated could

not help but be reminded of the strenuous life he had led. The second was the modesty of the man. Nobody could have been more modest and humble in the way in which he spoke of himself than Dr. Dudgeon ; he seemed as if he were afraid to pass an opinion. He (Dr. Moir) agreed with Dr. Clarke that the Society and the world at large had lost a great man. No man could have taken a higher standing in his profession, and if he had had a little "push" he would have been unrivalled. The third point was how he had done his work. In that respect he had left all survivors a lesson. While Dr. Dudgeon thoroughly enjoyed his work, he also enjoyed his play. No one was keener on golf. One afternoon a week had been given up to that recreation, which he allowed nothing to interfere with. His family had something to be proud of in the record of his life-long work.

The resolution was carried in silence.

The PRESIDENT thought some fitting memorial of their departed friend should be made. For instance, they might always have his bust before them when they entered that room, and he also thought that some encouragement might be given to younger men to study and strive as Dr. Dudgeon had done.

Mr. KNOX SHAW thought it would be fitting that the Council of the Society should consider the best form the memorial to their distinguished colleague should assume, and he therefore moved that the Secretaries call an early meeting of the Council to consider what form the memorial should take, and report to the next meeting of the Society.

Dr. GRANVILLE HEY, in seconding the resolution, said that as the youngest member of the Society, and perhaps one of the last to make the acquaintance of Dr. Dudgeon, he wished to re-echo all that had been said. The first time he met Dr. Dudgeon was about two years ago, and he could not help being impressed by his great geniality and, as the acquaintance deepened, by the other qualities which had been mentioned.

Dr. E. A. NEATBY, in supporting the resolution, thought a little careful consideration was required as to what form the memorial should take, but there could be no two opinions as to whether or not there should be a memorial. It was quite true that they had only to look around them to see a monument of Dr. Dudgeon, but at the same time something which came from themselves and was an expression, small though it might be, of their affection, admiration and reverence, was certainly called for. It was the first act of his (Dr. Neatby's) official life as Secretary of the Society to intimate to the members the death of Dr.

Dudgeon, which was an extremely sorrowful task. He would like to mention two or three points in regard to Dr. Dudgeon which, to his mind, were characteristic of him. The first was in reference to a remark made by Dr. Blackley as to how ready Dr. Dudgeon was to help beginners. It was about twenty years ago since he (the speaker) passed his first summer in practice in London; he was left without assistance through the absence of most men from town. Happily he found that Dr. Dudgeon had not gone away, and he asked his assistance in the case of a young girl, about seven years old, who was suffering from peritonitis. Dr. Dudgeon came and saw the case, gave him the support which, as a trembling beginner, he needed, and approved of the treatment, and through his piloting the patient pulled through. In the same summer he asked Dr. Dudgeon's advice in a case of puerperal eclampsia, and Dr. Dudgeon's characteristic modesty was then brought out, because he said: "This is not very much in my line; I think you could get somebody who could help you more than I can; send for Duncan Mathieson." Duncan Mathieson came, and Dudgeon took a second place in the consultation. He also wished to refer to his kindness in literary work. At the time when he (Dr. Neatby) shared some of the responsibility for the *Monthly Homœopathic Review* Dr. Dudgeon was always ready to step in and fill up a gap, either by writing an article or translating something which was sent him in a hurry, or by throwing some light on an obscure passage of translation. Only a few months ago, one of the last public acts of Dr. Dudgeon was to come, at his request, and give a lecture at a large drawing-room meeting in connection with the Ladies' Guild of the London Homœopathic Hospital. Although he was then 84 years of age, he cheerfully came out late at night to meet his audience and give his lecture. That was only a solitary instance of his self-denying kindness and devotion to the interests of homœopathy.

The resolution was carried unanimously.

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**SOCIETY NEWS.****INTERNATIONAL HOMŒOPATHIC CONGRESS.**

At the meeting in October, the following resolution relating to the International Homœopathic Congress was unanimously passed: "That the members of this Society are of opinion (1) that the most suitable date for the forthcoming International Homœopathic Congress would be during the year 1906; and (2) that in order to secure the greatest number of representatives from Great Britain and the European continent it is desirable that the meeting take place about the middle of September."

**NEW MEMBERS.**

At the meeting in November, Thomas Miller Neatby, M.A. Cantab. and Lond., M.R.C.S., L.R.C.P.Lond., of 25, Petherton Road, Highbury New Park, N., was elected a member of the Society.

**NEW MEMBERS—LIVERPOOL BRANCH.**

At a meeting in December, it was announced that the following gentlemen had been elected as members of the Liverpool Branch: James Hawkes, M.B., Ch.B.Vict. and Liv., 22, Abercromby Square, Liverpool; Alfred James Hynd, M.B., C.M.Aberd., D.P.H., Hahnemann Hospital, Liverpool; Thomas Chalmers Hynd, M.B., C.M.Aberd., 11, Standishgate, Wigan.

**THE LATE MR. G. A. CROSS.**

At the meeting in November, the President of the Society referred to the death of Mr. G. A. Cross, who had held the post of Secretary to the London Homœopathic Hospital for more than twenty-five years. Homœopathy had sustained a serious loss in the death of Mr. Cross, whose services had been invaluable. All members of the Society regretted his death, and condoled with his sorrowing widow and family in his sudden departure.



## THE LIBRARY.

A valuable addition has been made to the Library in the bequest of the late Dr. Dudgeon, that on his decease the medical part of his library should become the property of the Society. In Dr. Dudgeon's collection there are a number of surplus volumes which are at the disposal of members of the Society.

## THE DUDGEON MEMORIAL.

At the meeting in December it was resolved that the sum of two hundred and fifty pounds should be raised as a memorial to the late Dr. Dudgeon, part of which should be expended in the purchase of a portrait, and the remainder in some other object pertaining to the spread of homœopathic principles or practice.

## LIVERPOOL BRANCH.

*Annual Report for the Session 1903-04.*

The opening meeting of the Session was held on Thursday, October 8, when Dr. C. W. Hayward delivered his presidential address, entitled "Rationalism and Medicine."

The other papers presented before the Society were as follows: November 12, 1903, "Our Heritage and Responsibilities," Dr. Thomas Simpson; December 10, 1903, "Drug Treatment of Epilepsy," Dr. Edmund Hughes; January 14, 1904, "Physiological Therapeutics," Dr. Sydney Whitaker; February 11, 1904, "Résumé of Cancer," Dr. C. T. Green; March 10, 1904, "Leaders in Homœopathic Philosophy," Dr. Watson; April 14, 1904, "Some Observations on the Physiology and the Hygiene of the Eye," Dr. Lucas Hughes; May 12, 1904, "Davos as a Health Resort," Dr. A. E. Hawkes.

It is to be regretted that, with papers of such wide and varied interests and a membership roll of thirty-four, an average attendance of ten only was obtained at the meetings of the Branch. The balance of funds in hand is £2 9s.

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## SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

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*Extracted from Exchange and other Journals by the Editor, in collaboration with J. G. Blackley, M.B., T. G. Stonham, M.D., and C. J. Wilkinson, M.R.C.S.*

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**Acetozone in Typhoid Fever.**—Dr. W. W. Ross gives an account of acetozone in the September *Brooklyn Medical Journal*. Acetozone is benzoyl-acetyl-peroxide, a compound of peroxide of hydrogen, but possessed of much greater germicidal power. It is soluble in water in the proportion of 1 to 1,000, and in its presence, which is necessary for the development of its power, it undergoes hydrolysis, splitting up various peroxides, one of which, acetyl hydrogen peroxide, is an active germicidal agent, and it is to this that acetozone owes its antiseptic property. It has no constitutional effect, and is not poisonous, even when taken in large quantities, and is also entirely harmless to mucous membrane in a saturated solution. Professor Novy reports that water containing one million typhoid bacilli per cc. was rendered sterile in fifteen minutes by adding crystals of acetozone, and that acetozone is germicidal in the strength of 1 to 33,000. Professors Novy and Freel report having fed students on milk and acetozone for several days, and during the whole time the fæces were entirely sterile and the men quite healthy.

On account of these qualities acetozone has been used in the treatment of typhoid fever as an intestinal germicide and antiseptic, and, Dr. Ross states, with excellent results. He quotes the experience of himself and of many other physicians, and claims for it that the fæces are completely deodorised within seventy-two hours, and in the same time diarrhœa, when present, ceases, and the tongue becomes moister and cleaner, the heart's action stronger, the temperature lower, the disease is shortened by as much as a week, relapses are prevented, and the mortality is reduced. To administer it, a saturated solution should be made

by dissolving 15 grains in a quart of water at 90°. It should be stirred vigorously for a few minutes, and then the hazy solution should be allowed to stand two hours for hydrolysis to begin. Of this solution 30 to 40 ozs. should be taken in divided doses in twenty-four hours; and since it is decomposed by organic matter it should be given on an empty stomach. It may be flavoured with lemon, orange, or saccharin. Its use is not confined to typhoid fever, but it may be used to destroy germs wherever they exist, *e.g.*, in abscesses, bacterial diseases of nose, throat and mouth, and in gastro-intestinal affections with great fermentation, as dilated stomach. (*Brooklyn Medical Journal*, September, 1904.)  
—T. G. S.

**Adrenalin.** *Physiological and Therapeutic Action.*—Adrenalin has, in the healthy man, a constant effect upon the arterial tension. Hypertension is the phenomenon which has been chiefly noted, but there is no doubt that this hypertension alternates, in certain little-known conditions, with an opposite state of hypotension. As yet no experiments have been made upon the different effects of strong and feeble doses, which is to be regretted.

Adrenalin causes diminution of red globules and increase of leucocytes; it produces, therefore, *anæmia*. Glycæmia and glycosuria are also produced by it, and it has caused the classic lesions of chronic aortitis. It is known, moreover, that deprivation of adrenalin in consequence of destruction or disease of the suprarenal capsules produces a pathological complexus of symptoms differing from and in some points opposed to the above. Adrenalin has, like *thyroidin*, a double therapeutic action; it either offers to the organism the adrenalin which is lacking, as in the treatment of Addison's disease—that is, opotherapy—or it influences the course of diseases by the therapeutic properties which experiment has taught, and in this case its indications ought to be determined by the law of similars. It should be added that the knowledge of the action of adrenalin upon the healthy organism still presents too many *lacunæ* for us to give absolute rules for its employment as a drug in the treatment of disease.

According to the law of similars, adrenalin would be indicated in arterio-sclerosis, and particularly in aortitis, in anæmia, and perhaps in diabetes. Guided by this law, Jousset has been employing adrenalin for several years, and the preparation which he prefers is the hydrochloride in the sixth decimal dilution. He

relates a case of extreme chlorosis treated by adrenalin, where the asthenia was so great that the patient could hardly rise to make her bed. The anæmia was profound, and the menses had been absent for several months. Anorexia and dyspepsia were so marked that nothing but liquids were tolerated; there was obstinate constipation, great depression of spirits, and a highly nervous condition. Previous medication had been without result; the most that had been achieved from time to time was the ability to digest a little solid food, or the diminution for a time of the constipation. On May 26, 1902, treatment by adrenalin was commenced, and the drug was prescribed as follows: Four grammes of the 6x trituration were divided into sixteen powders, and the patient took one of these every fourth day. This was continued steadily for three months, when the patient testified to a general improvement. The dyspepsia, above all, was relieved, and the patient began to eat, and to put on flesh. The treatment was continued, but the drug was now given every day, the dose remaining the same. Improvement became more marked, and at length, on January 26, 1903, eight months after the commencement of the treatment, the menses, after being absent for several years, reappeared, and have since been regular. The constipation is less, the stomach has resumed its functions, and the patient has begun to walk out, and strength is gradually returning.


Jousset has also given the drug to a child, the subject of hæmophilia. The child belongs to a family where all the boys are hæmophiles, but not the girls. He takes adrenalin for a fortnight and then rests for a fortnight. Since using the drug, though he still has ecchymoses, there are no true hæmorrhages. Within the last few months Jousset has begun to prescribe adrenalin for arterio-sclerosis, and records the case of a gouty patient of 55, subject to frequent crises of angina pectoris, for whom iodide of sodium had done nothing. Since adrenalin was commenced the crises have entirely ceased. In two patients, the subjects of chronic aortitis, he has obtained very notable amelioration by the exhibition of this drug. (*Revue Homœopathique Française*, June, 1904, p. 226.)—J. G. B.

**Anilinum.** *Poisoning.*—A case of chronic poisoning due to the habitual moistening of an “indelible” pencil in the mouth is recorded by Dr. Harvey. A provisional diagnosis of ptomaine poisoning or oral poisoning by micro-organisms was for some time held. The symptoms were painful swelling of the lips and gums, so severe as to prevent the patient (a married woman of 27) from

taking solid food. There was no ptyalism. A fortnight later discolouration of the inner surface of the gums was noticed. The gums showed pigmentation, dark blue in colour, somewhat brighter than that of a lead line. It was more a band than a line, and was situated at the alveolar margin, being most marked at the sites of carious teeth, and could be seen on both the labial and lingual aspects. The bands on the mucous membrane of the cheeks were less definite in outline and were about half an inch deep. There was great dyspnoea and nausea, with vomiting immediately after ingestion, the nature of the food having no influence on the vomiting. The patient was pale and sallow, but not markedly anæmic. The breath was offensive and the tongue was coated with brownish fur. The urine, which had previously been very dark, had a specific gravity of 1018, was acid, and contained no albumin. No organic disease was found, and there was no sign of paralysis. (*Lancet*, October 1, 1904.)—C. J. W.

**Aurum in Mental Disorders.**—Dr. Frank Kraft relates the case of a lady of 25 to 30 years of age, married and in good circumstances, apparently healthy, but without children. She came complaining of headaches beginning in the morning, like a bruised pain, when studying, writing, or talking, but lessening as she left off mental work and disappearing entirely in the evening. Treatment for this headache gave no results, but fresh symptoms were elicited subsequent to an attempt at suicide by throwing herself in front of a train. It was then discovered that she had been growing melancholy on account of her barrenness, was sleepless at nights, feared she was losing all attraction for her husband, &c. She was at once given aurum metallicum (dose not stated). The insane symptoms soon departed, and she afterwards became the mother of three children. (*Medical Century*, September, 1904.)—T. G. S.

**Borax. Poisoning.**—Of six cats, to whose diet borax was added in different quantities for varying periods, five were found to exhibit signs of nephritis. Stained sections of the kidneys showed lesions of the same character differing in intensity. The epithelium of the tubes, particularly of the convoluted tubes, was degenerated. The normal fat vacuolation was greatly increased, and the cells were swollen in places, disintegrated with fragmentation of nuclei. In the lumen of many of the collecting tubules were granular masses representing cell fragments. Some tubules



were almost completely stripped of epithelium. In one kidney the change was confined to intense degeneration, with hyaline casts in the small tubes. In others the degeneration was not so intense, but was accompanied by foci of cellular infiltration, chiefly marked at the cortex. Where the infiltration was most intense the tubules were entirely destroyed. The lesions were analogous to those of subacute and chronic nephritis in man, but did not correspond to any definite type. (*Lancet*, September 17, 1904.)—C. J. W.

**Digitalin Crystallised.** *Its Action in very Small Doses.*—Huchard's crystallised digitalin in doses of 5 drops of a 1—10,000 solution is particularly adapted to those cases where we have to deal with profound changes in the muscular fibres of the heart, and where gentle and long-continued stimulation of the organ gives no risk of exhaustion. The dose is repeated on ten successive days. In cases of arterio-sclerosis of the heart, with or without renal sclerosis, where milk diet and theobromin have given no relief, digitalin in minute doses may be thought of. Fiessinger gives the two following illustrative cases. (1) A man of 55, previously healthy, had for a year past complained of shortness of breath on going uphill. On examination the signs were those of interstitial nephritis, intoxication, and neurasthenia of venous origin, viz., increased arterial pressure, galloping action of heart, albuminuria, decrease of urea, somnolence, rapid fatigue, and paleness of face. Before long the shortness of breath had increased, so much that he could not walk even the shortest distance. Sleep was practically absent. The usual signs of dilatation of the right heart were present — venous pulsation of the jugulars, liver enlarged and tender, œdema of lower extremities. Cupping over the liver, rest in bed and a milk diet were ordered at once. On the following day digitalin was prescribed in a somewhat strong dose (10 drops of a 1—5,000 solution). This quantity was given daily for four days, with the result that all signs of dilatation vanished, and the accelerated heart-beat only appeared on walking. In order to keep up the good effect, the patient was ordered  $\frac{1}{10}$  of a milligramme each day for ten days, with a milky and vegetable diet. At the end of the ten days he was able to resume business, though he still felt some oppression on walking quickly. He slept well, had quite lost his pallor, and was not so easily tired as before. At the end of eleven months the improvement was still maintained. (2) This was the case of an old lady of 82, suffering from cardiac

and renal sclerosis, with albuminuria. In 1902 she suffered much from dyspnoea, which was relieved by a milk diet. In April, 1903, had an attack of acute cedema of the lungs, with arrhythmia and tachycardia—pulse 140 to 160 in the minute and irregular. Theobromin gave partial relief by causing diuresis; strophanthus was without effect. In May digitalin was begun,  $\frac{1}{10}$  of a milligramme per day. After a few days there was less dyspnoea, the obstructed bronchial tubes became free, and the cedema of the lower extremities vanished. After the remedy had been given for three periods of ten days each, with intervals of fourteen days between, the arrhythmia had completely vanished, the pulse-beats being 70 in the minute, regular and distinct. An intercurrent attack of glycosuria (100 grammes in twenty-four hours), probably the result of immoderate use of sugar, treated with arseniate of soda, did not act prejudicially upon the commencing improvement of the heart affection. In spite of the advanced age of the patient and the cardio-sclerosis undoubtedly present, the condition improved in an altogether unexpected manner. These facts, says Dr. Fiessinger, show plainly that small doses, given according to proper indications, act as well as strong doses as anti-systolics. Even in patients whose hearts are enfeebled by the previous use of digitalis, the smallest doses may be given, whilst the medium and, *à fortiori*, the strong doses may produce very unpleasant effects. (*L'Art Medical*, February, 1904.)—J. G. B.

**Eserin Salicylate in Intestinal Paresis.**—Dr. C. Jewett reports a case of operation for ectopic gestation. The right tube and ovary, and the appendix and meso-appendix were removed, and a phimosis operation was done on the left tube. At the end of three days the abdomen was enormously distended, and all the usual measures had failed to move the bowels. The patient had vomited steadily since the operation. A hypodermic injection of  $\frac{1}{80}$  gr. of salicylate of eserine was administered. Within a few hours vomiting had ceased, and toward the end of twelve hours, as the bowels had not acted, the eserine was repeated. Within a short time after this second dose there was a free evacuation, and later five or six more.

Eserine prevents or counteracts intestinal paresis, both directly by stimulating peristalsis, and also by combating the spinal reflex inhibitory effect upon the peristalsis which comes from the irritation of the splanchnics. (*Brooklyn Medical Journal*, August, 1904.)—T. G. S.

**Lysol. Poisoning.**—A healthy man of 47 drank by mistake a mouthful of commercial lysol. Immediately afterwards he took some milk, but a very few minutes later he began to tumble about, and was at once put to bed. Half an hour later he was seen by the doctor who found the usual appearances of a caustic poison on lower lip and gums. The patient was somnolent, but could still tell what had happened. Fifteen minutes later the stomach pump was used and by this time the man was unconscious, the face pale and the conjunctivæ reddened; corneal reflex was present, pupils moderately dilated, pulse somewhat quickened but regular; loud snoring respiration; the whole appearances were those of a severe debauch. The stomach was washed out with 15 litres of water, and after half an hour the patient woke up, and except for the pain in the mouth and stomach, felt quite well. He had no remembrance of anything that had occurred after the first symptoms came on. (*Schwarz Prag. Med. Wochenschrift*, No. 27, 1903.)—J. G. B.

**Oleander. Poisoning.**—The toxic effects of this shrub are used by soldiers with a view to obtaining a furlough. An infusion of a handful of the leaves in boiling water is drunk. In a case recently observed by Dr. Bonnette, in South Oran, the symptoms commenced with nausea, vertigo, prostration, and a fall of temperature to 97·5° F.; the extremities became cold, with dilatation of the pupils, loss of pupillary reflex and anæsthesia of the cornea. The heart became irregular and the pulse slow and thready, with gasping breathing, constipation, and mental confusion merging into coma. These symptoms lasted throughout one day, and recovery set in with green diarrhoea and a copious excretion of dark urine. The heart remained slow for some time after. (*Medical Press and Circular*, September 11, 1904.)—C. J. W.

**Natrum Muriaticum in Anæmia.**—Dr. Lambert has quoted the following case to illustrate a clinical lecture on natrum muriaticum. Elizabeth Davis, aged 43, admitted April 6, 1902, complaining that she had been ill four years, for two years of which time she had been under allopathic treatment. She was intensely anæmic, and the skin had a yellow tinge. In addition to the usual symptoms of severe anæmia, viz., shortness of breath, palpitation and great weakness, she complained of the following: Hands and feet cold and “so dead,” the coldness reaching to the knees and the feet swelling; light-headed and suffers from vertigo; thirsty and craves acids; appetite good and no pain after food, but gets flatulence from drinking cold water.



Bowels regular. Had piles twelve months ago, which bled occasionally. Catamenia regular, not excessive, and without pain. Very low spirited. Physical examination disclosed hæmic bruits all over cardiac area, lowest over left auricle. First mitral sound reduplicated. Venous pulsation visible in neck and over the chest. Marked pulsation of abdominal aorta. She was given *natr. mur.* 30 *ter die*. She improved through April and May. A change to the sixth dilution caused an aggravation in June. She was admitted to hospital as in-patient in July, when a blood count gave red corpuscles 1,900,000; hæmoglobin 40 per cent.; colour index, 1.05. She improved much while in hospital, still under *natr. mur.*, and the improvement continued all through the next winter and following summer. She became so well that she left off treatment, but relapsed during the great heat of the next summer after she had left off taking the medicine for six months. She was again put on it and improvement recommenced. (Dr. Lambert, quoted by *Medical Century*, October, 1904.)—T. G. S.

**Phosphorus.** *Tetanus produced by Poisoning.*—A woman, with the object of committing suicide, took the heads of thirteen boxes of ordinary matches, representing a quantity of about 0.65 gramme of phosphorus. Three hours later her stomach was washed out with 60 litres of sterile water, and she received infusion of senna by the mouth and a high rectal injection. During the night the patient had two copious diarrhœic stools, and by means of Scherer's test phosphorus was detected in the fæces. At the end of four days bilateral tonic spasms in the upper extremities and on both sides of the face were set up. The finger-joints and wrists were flexed, the forearm bent at the elbow, and the upper arm adducted to the trunk. The phenomena of Stokes and Trousseau were very pronounced; the latter could not be elicited in the lower extremities, but tonic spasms came on when the patient walked about. Sensory excitability was decidedly below normal, especially the sense of temperature. The tetanic symptoms vanished after a few days. This case was that form of tetanus caused by rapid absorption of poisonous substances and their effect upon the whole nervous system. The characteristic symptom-complex of tetanus occurred at the moment when the evidences of phosphorus intoxication reached their highest point, and vanished altogether as the poison was excreted from the body. (*Prag. Med. Wochenschrift*, No. 37, 1903.)—J. G. B.



**Serpent Venom.** *Action of Bungarus fasciatus on the Nervous System*—In a series of experiments on monkeys with a view to bringing out the differences between the poison of *Bungarus fasciatus* (banded krait) and the cobra venom on the nervous system, Drs. George Lamb and Walter K. Hunter found that the effects of the former were longer lasting and frequently less immediately lethal than the latter. It is possible, therefore, to watch and describe them more in detail. Seven monkeys were employed for the purpose and the following is a summary of results. These results may be expressed from both the symptomatological and pathological points of view. (1) *Symptomatology*: In cases where the poison has not appeared to take immediate effect, having been injected in small quantity, for a few days it was observed that the animal did not eat much and was more or less depressed. A rapid and progressive loss of weight takes place. After this, symptoms more pronounced show themselves. There are loss of appetite and great depression, but marked muscular weakness and atrophy, extreme emaciation and loss of weight are the prominent symptoms. There is marked diminution in the urinary secretion, and irregular elevations of temperature are sometimes observed. Purulent discharges from the eyes, nose and rectum are late symptoms. The emaciation, loss of weight, and muscular atrophy progress rapidly and end in death after a few days' illness. In some cases it was possible to observe that paralysis was present and became complete before death. The symptoms all point to serious interference with the functions of the nervous tissue, in fact, to a direct action of the poison on these tissues. (2) *Pathological appearances*: By comparison with cobra venom, the venom of *Bungarus fasciatus* has only a slight destructive action on the red blood corpuscles, and the effects of its action on blood coagulability are not of such a nature as to produce symptoms. Histological examination of the central nervous system and peripheral nerves was made in five cases. The condition discovered may be described as an acute chromatolytic degeneration of the central cells of the motor regions of the cord and the cerebral cortex, and less so of the medulla. In the first there is a deep and rather diffuse staining of the ganglion cells. In this diffusely stained plasma the Nissl granules are to be seen as deeper-stained bodies, still quite consistent, but with rather ill-defined edges. The Nissl bodies next seem to begin to dissolve in the cell plasma, and they suggest the appearance of pieces of metal being acted upon in a strong acid medium. Then the granules and diffuse staining begin to disappear and leave a

skeleton cell with its margin, reticulum and nucleus somewhat deeply stained, but very well differentiated. Later, the staining becomes gradually less intense, till we reach the stage in which the cell is little more than a shadow of its former self—the typical ghost-cell. Vacuoles next appear in the body of the cell and its margins become indented, as if little pieces had been snipped out. Then portions of the cell disappear altogether and leave little more than a nucleus with the remains of the cell reticulum attached to it. All this time the nucleus, at least in a large proportion of the cells, seems to be little affected otherwise than is shown by a varying intensity of its staining. It remains central, is only exceptionally found at the periphery of the cell, and though it is sometimes lost to view in the diffuse staining of the earlier stages it is almost always to be seen in the later stages of degeneration. Vacuolation is most seen in the pale (“ghost-” cell) stage, but it is also to be met with in the more deeply-stained cells. The connective tissue elements of the gray matter seems to play a somewhat secondary part in this degenerative process. They may be slightly increased in number round the ganglion cell in its earlier stages of chromatolysis, but this increase is not in the least considerable, and it is not till vacuolation comes on and the cell begins to break up that they are seen to cluster definitely round the disappearing cell. During this later stage, and sometimes also at an earlier stage, they are found indenting the margins and are sometimes right inside the body of the cell. The chromatolytic changes just described seem to be uniformly most advanced in the smaller cortical cells and in the cells of the more central groups in the anterior horns of the cord. The larger cortical cells and certain of the cells in the lateral groups of the anterior horns seem to be considerably more resistant to the toxin, for they are slower in showing degeneration and when it does appear it is almost never so extreme as in those other cells. Of the motor nuclei in the pons and medulla the ganglion cells of the third and fifth nuclei were usually affected about equally with those of the cortex and cord. But the seventh, tenth, and twelfth nuclei showed changes more seldom, at a later period, and of a less intensity than any of the other motor cells in any part of the central nervous system. The condition produced by this venom is for all practical purposes an acute polio-encephalitis and myelitis, both from the symptomatological and histological points of view. (*Lancet*, October 22, 1904.)—ED.

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*All communications and exchanges to be sent to*

DR. GOLDSBROUGH, 82, Wimpole Street, London, W.

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EXPERIENCES IN THE LATE SOUTH AFRICAN  
CAMPAIGN, WITH SPECIAL REFERENCE  
TO ABDOMINAL WOUNDS.<sup>1</sup>

BY ROBERT M. LE H. COOPER, M.D., B.S.DURH.,  
M.R.C.S., L.R.C.P.LOND.

My feelings were those of great surprise when I was first honoured with a request to give you a few of my experiences in South Africa, for I had previously regarded the subject of bullet-wounds as of but small interest to surgeons outside the Service. I should never have had the temerity to offer, on my own account, to read a paper before you dealing with wounds which are but rarely met with in civilian life. I therefore wash my hands of responsibility in the matter, and crave your indulgence if my paper proves to be a dull one.

I had not commenced recording my experiences on paper for long, before I saw the utter impossibility of cramming all the experiences of two and a half years into a paper so limited

<sup>1</sup> Presented to the Section of Surgery and Gynæcology, December 1, 1904.

in time, without completely failing to do justice to the various points worthy of consideration. I therefore decided to take up one subject alone and stick to it, and my choice finally fell upon bullet-wounds of the abdomen. I should very much have liked to give you some idea of our many journeyings and the many difficulties we encountered owing to lack of trained men, insufficient transport and half rations, but time compels me to confine myself to stating that I sailed with the 8th Division from England on that happy day set apart for the glorification of the august St. Patrick, in the year 1900. Fortunately for me and for this paper, a lack of senior officers gave me the position of second in command of the 21st Field Hospital, otherwise known as the Guards' Hospital of the 8th Division, and when on arrival in South Africa the hospital was split into two, I had control of one half, and so became Senior Medical Officer of General Boyes' Brigade. I was entirely responsible for all the medical arrangements of this brigade, and consequently had under my personal supervision all the most important cases which occurred. It was because I was fortunate in treating a good many cases of abdominal wounds, and because the question of treatment of this particular kind of wound has given rise to much controversy, that I have chosen this subject for my paper to-night.

Before going on to the cases themselves, perhaps it will not be amiss briefly to describe the bullets chiefly employed by the enemy. Probably, if the truth were known, it would be found that there was no type of bullet ever invented a representative of which was not, at one time or other, used by the Boers. I had collected a very large number of these, including practically every variety, together with sections of shells, etc., but, as most of these were stolen on my way home, I have had to content myself with showing you some of the varieties on the screen. The first two (fig. 1) on the left are the so-called soft-nosed bullet. The Boers made these by filing away the outer covering of the ordinary Mauser, to expose the leaden core at the business end of the bullet. The object of this, of course, was to allow of expansion of the soft core on impact, and so to render the projectile far

more deadly. The remainder of the slide is occupied by a variety of specimens of large-calibre leaden carbine and rifle bullets. You will see that some are of large size and that many are cupped or flattened at the apex. I may here say that I am indebted to Mr. Makins for many of the slides I am showing this evening, having had them copied, by his kind permission, from illustrations in his book.<sup>1</sup>

Fig. 2, my next slide, shows the main types of bullet used, and represents from right to left the Martini-Henry, Guedes, Lee-Metford, Mauser, and Krag-Jørgensen. The last four are representatives of the modern small-bore bullet, and for all practical purposes may be said to produce wounds of a

FIG. 1.

Two soft-nosed bullets on the left. The remainder are large size leaden bullets.

similar nature. The four varieties shown differ slightly in calibre, the largest being the Guedes (.314 ins.), No. 2 on the slide, and the smallest the Krag-Jørgensen (.254 ins.), at the end of the row. The core of all four bullets is composed of lead, hardened by a certain mixture of tin or antimony, but though the mantles differ somewhat in composition and thickness, both in general and in different parts of the bullet, no definite evidence is forthcoming to show that this makes much practical difference to the effects produced. Time does not permit me to go into this matter deeply, so I will content myself with showing a section of these bullets and saying that the Lee-Metford, No. 2, on the slide, has a mantle composed of

<sup>1</sup> Only original sketches and photos by the Author are reproduced.

an alloy of nickel and copper, while the remainder are steel-clad, the Mauser and Krag-Jørgensen, Nos. 2 and 3, having in addition a thin coating of alloy to take the rifling of the barrel. The slide shows well the greater thickness of the Lee-Netford mantle, which, added to its greater hardness, renders it less liable to split or become deformed. There is therefore, good reason for believing that it is the most humane



FIG. 2.

The five main types of cartridges used in the South African War. From left to right—Krag-Jørgensen, Mauser, Lee-Netford, Guelles and Martini-Henry. They become progressively larger in calibre from left to right.

of all the modern bullets. Fig. 3 shows a diagrammatic representation of the relative thickness of the Mauser and Lee-Netford mantles. The mantles of the other bullets mentioned are similar in thickness to that of the Mauser.

The Boers found that the thin coating for taking the rifling was not sufficient, and so they covered their bullets with

paraffin wax. The action of this on the copper alloy produced verdigris, and it was the green colour so produced which gave rise to the suggestion of poisoned bullets being employed, and this, you may remember, caused a great *furor* at one time.

There were a few cases of a very virulent septic gangrene which, it was suggested, were produced by these bullets, but investigation exploded this idea. I had one such case myself in which I had to amputate at the hip joint, but I should be digressing if I attempted to describe it. That the stir made about the poisonous properties of the verdigrised bullet reached the ears of the Boers, and that they actually went

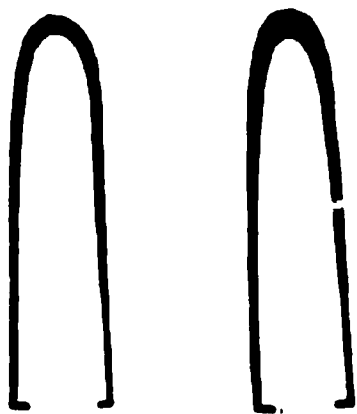


FIG. 3

Diagram to show relative thickness between the mantles of the Mauser, on the left, and the Lee-Metford, on the right.

out of their way to cover their bullets with a thick coating of this, in the hopes of doing more damage, I am convinced. I think the specimen on the table is a proof of this, as no such thick coating is apparent on bullets which have become green in the ordinary way.

Besides scraping off a portion of the envelope, the Boers had many devices for increasing the lethal effect of their projectiles, and they exercised their inventive genius and occupied their spare time in producing such varieties as are seen in the next slide (fig. 4). In the centre is seen a cross-cut leaden bullet, on the left a Lee-Metford with an exposed tip, and on the right a Mauser, the top of which is seen to be flattened, longitudinal slits having been made in the mantle in addition. Another modification of the Martini-Henry was that in which a hole was bored down the centre and a wooden plug inserted.

Prior to the introduction of the small-bore bullet into modern warfare, military surgery laid down the absolute and definite rule that in cases of penetrating gun-shot wound of the abdomen, there was only one course of action open to the surgeon. "*He must operate*, or the man would certainly die;" the chance of recovery being so exceedingly remote that it was regarded as a negligible quantity. So it happened that this rule was carried out at the commencement of the South African campaign by civilian as well as army surgeons, many of the former being especially skilled in abdominal surgery. It happened, however, that some cases could not be operated on, owing to diverse circumstances, and a large percentage of these recovered, whereas the figures shown for cases operated on were most unfavourable. Hence, as is usual in such cases, the pendulum swung to the other extreme



FIG. 4.

To show how some bullets were tampered with to make them more deadly. The bullet on the left has had the mantle removed at the tip. That on the right is flat tipped and has longitudinal cuts in the mantle.

and the tendency was not to operate on any such cases. This was going too far, but it is certain the cases which justify immediate operation in the field are extremely remote.

In consideration of this question it must be borne in mind how very unfavourable are the conditions which pertain in war-time for the successful performance of laparotomy, and to help you to realise this more fully, I will endeavour to call up before you a vision of the conditions under which such an operation would probably have to be undertaken.

The foremost part of the column has but recently halted and is now engaged in camping for the night. The medical units have drawn up their ambulances and general service



waggons in line, close to their allotted ground and are busily engaged unloading the equipment from the latter. An operating tent, consisting of a single sheet of canvas, with a floor area of  $20 \times 14$  feet, and a height at the ridge pole of 9 feet, is soon run up on the cleanest spot of ground available. The canvas of this tent is full of dust collected in its many wanderings, and more dust, stirred up by the semi-hurricane outside, is blowing through the ventilators and under the flaps. Orderlies in dusty uniforms, fresh from the march, hurry to and fro placing the travel-stained panniers in position and fixing the operating table. If the medical officer in charge has previously used spare moments to advantage, he has drilled into these men the necessity of brushing their uniforms and sterilizing their hands, before commencing to remove the antiseptic and aseptic dressings from the cases. The wrappers of these would only be opened at the last moment, but how, under such conditions, could even a pretence at asepsis be obtained? The surgeon himself has only just come off the march, his hair and uniform are full of dust, and there has been no time to perform thorough ablutions or change his clothes. All he can do is to clean his hands and attempt to sterilize them in an antiseptic lotion; but how has this lotion been prepared?

Water choked up with a fine sand, which refuses to settle when allowed to stand, even if time could be obtained to attempt this, has been forcibly squeezed through a refractory Berkefeld filter, which showed its disgust at being required to deal with such a liquid by bursting the rubber washers every few minutes, and spraying concentrated, unfiltered water into the bucket receiving the clean water. If time has permitted, this water has been boiled, but a camp kettle can hardly be regarded as an ideal boiler for such a purpose, and dust easily finds its way into the lotions when made, however carefully protected.

With regard to the nature of this dust, every medical officer in command of a field hospital naturally insists on the cleanest part of the camping ground being reserved for his tents, but it sometimes happens that military exigencies necessitate the camp being pitched on the site of previous

camps, and when this is the case it is obvious that the dust in this situation must be highly dangerous from the surgeon's point of view.

As to the patient himself, in all probability he has had no opportunity of washing himself, or even taking off his clothes for weeks, and to thoroughly sterilize his skin would require more time than is available.

I need not continue to dilate further upon this aspect of the question, as imagination can well supply the rest, and I think you will agree that the recovery of a case of laparotomy conducted under such conditions would be nothing short of miraculous. Of course, if a London hospital was at hand with all the necessary appliances, the case would be different, but even then there would be many cases in which immediate laparotomy would not be justifiable.

I went out to South Africa by no means convinced that operation would be so seldom justified, but my first case served to open my eyes considerably on this point. It was that of a captain in the 11th Hussars who was brought to me the day after our arrival in Thabanchu. He stated that he had been wounded two days previously ; and on examination I found that the bullet had entered the back, close to the right side of the third lumbar vertebra. It had passed diagonally across the abdominal cavity from right to left, and after perforating the left ilium, had emerged at a point below and posterior to the anterior superior spine of that bone. The exit wound was slightly larger than the entrance wound, this latter being about the size of a three-penny piece. An area of ecchymosis surrounded the exit wound, having a radius of about two inches, but I could detect no splintering of the bone on palpation. Prior to its entrance into the body, the bullet had passed through a leather case, containing field glasses, which were shattered to pieces, and also through the haversack with its contents. This was of importance, as it suggested the possibility of the axis of the bullet having been deflected, in which case the intestines would have run the risk of dangerous laceration. However, from the appearance of the entrance wound and the mildness of the symptoms, it did not seem possible that any such deflection had taken

place. He complained of no actual pain, though movement caused slight discomfort, his bowels acted naturally and he took his nourishment in the form of milk and beef-tea without pain or discomfort. I impressed upon him the necessity for keeping as still as possible, but had great difficulty in enforcing this, owing to his restless disposition. In two days from the time of his admission, he was able to recline propped up against his valise, and in a week from the time of the receipt of his wound he was able to walk a short distance with the aid of a stick; he was regaining his strength rapidly, and his bowels were acting quite regularly.

The secret of these marvellous results lay in the conditions under which the wound was received and the early treatment which had been adopted prior to his coming under my care. In the first place, he had not had any food for some time before he was struck, and he had lain out many hours before being taken to a Boer doctor, who kept him without food for several more hours; this abstinence from food being the essential factor in the successful treatment of these cases. At first sight this seems a simple enough measure to employ, but I can assure you it is by no means so easy to carry out in practice, the difficulty in the way being the intense thirst which all wounded men suffer from and their positively agonizing appeals for something to allay it. Still, these are cases in which one must be cruel to be kind, for a small quantity of nourishment given too soon means death to the patient. I will, however, deal further with this question later on.

My next case is remarkable for its striking similarity to that which I have just described. The man was a trooper in the Yeomanry, who also was riding at the time of his injury. As in the former case, the bullet had entered at the right side of the lumbar spine, though at a somewhat higher level. It took an exactly similar direction across the abdomen from right to left, but its velocity must have been considerably less, for although there was no evidence of its having met with any obstruction before its entrance, it had failed to pierce the left ilium, and had evidently impinged against its inner surface. I arrived at this conclusion from

the condition of the skin over the ilium, there being at this spot an area of tumefaction and tenderness having an approximate diameter of five inches, but the bone itself I found to be intact. The entrance wound was insignificant in size. The man presented no symptoms calling for the immediate removal of the bullet, so I merely kept him at rest and denied him all nourishment by the mouth for twelve hours, and then began with occasional teaspoonfuls of milk given at rare intervals. These seemed to intensify rather than allay his thirst, and I had great difficulty in preventing the orderly in attendance from giving way to his constant appeals for more food. Besides the tenderness above referred to, he complained of only slight discomfort, and suffered no actual pain whatsoever. The behaviour of his bowels are of interest, for they ceased to move for three days and then acted naturally.

Cessation of peristalsis is the rule after abdominal wounds, and is, no doubt, one of the chief elements responsible for a favourable issue in such cases.

To my annoyance, the orderly in charge of the case neglected my previous orders and failed to retain the first evacuations for my inspection, so that I am unable to say if any clots were passed. Five days after the receipt of his injury, I sent him a distance of ten miles into the town of Senekal; he was then doing splendidly and was in the best of spirits.

The cases of abdominal wounds which came under my notice pointed to the fact that this class of wound was met with more frequently in the case of mounted men than in those on foot. People in England, perhaps, hardly realise how frequent was the practice among the Boers of displaying a white flag from a farm with the intention of attracting some weary trooper in search of milk or bread to relieve the monotony of his daily ration of biscuit and bully beef, and then treacherously shooting him from behind as he rode away. An abdominal wound was a frequent result in such cases, and the following was an example of this. The man, a trooper in the Yeomanry, together with two companions, had called at a farm from which fluttered the emblem of peace. They purchased some milk from the family, who

pretended to be quite friendly to them, and were riding away without a thought of immediate danger, when, having reached a distance of about fifty yards, some previously-concealed Boers commenced a continuous fusilade at them. Fortunately only one was hit, and the other two came in with the news, the man's body being subsequently brought into camp.

I found that the bullet had entered low down on the right side of the back, just above the iliac crest, and had travelled almost directly forwards to its point of exit above and close to the centre of Poupart's ligament. Unfortunately, I had no opportunity to make a *post-mortem* examination, but it was plain that the bullet had severed the right external iliac artery, and that the man could not have lived many minutes after he was hit.

It may be of interest to you to know that the penalty for such treachery was the removal of the family and destruction of the farm.

In another fatal case, in which a trooper of the Yeomanry had been sniped whilst acting as flank guard to a column on the march, the bullet entered the lower part of the back on the left side and crossed the abdomen diagonally, much as in the first two cases described, but it took a more downward course, and, passing into the right thigh, it severed the right femoral artery and emerged three inches below Poupart's ligament. This man also was beyond help by the time medical aid reached him.

The next case is that of a private of the Leinster Regiment, wounded while approaching a kopje, on which some of our Artillery were posted. He was some distance from the hill at the time, and the bullet, which had evidently been aimed at the gunners, must have been dropping at the time he was struck. It entered the abdomen above and to the left of the umbilicus, and, passing downwards, backwards, and outwards, it became lodged in the left gluteal muscles, from which point I removed it. You will see by the indentation near its point that it must have struck some hard substance in its flight, but the nickel envelope fortunately remained intact, otherwise the damage to the intes-

tines would certainly have been fatal. This patient was very little inconvenienced by his wound, and I treated him on the same principles I have mentioned above. He was doing excellently when I handed him over to the care of a hospital in Standerton two days later.

I have hitherto dealt with cases involving the lower half of the abdomen, which, as you have seen, were distinctly favourable in character, unless a vital structure, such as a main vessel, was perforated. The succeeding cases, however, which involved the upper abdomen, were by no means so favourable.

The first is that of a lieutenant of the Manchester Regiment who was wounded early one morning while on outpost duty. He was standing erect at the time, and the bullet entered the epigastric region about three inches below the costal margin and a little to the right of the middle line, and passed backwards and slightly downwards to emerge on the right side of the spine. In spite of the severe shock from which he was suffering, I think it remotely possible that, if an operation could have been undertaken under aseptic conditions immediately after he received the wound, with absolute rest to follow, his life might have been saved. It is also possible that, if the patient could have been starved and kept at rest, even without operation, there might have been some hope of his recovery, but circumstances allowed of neither of these measures being carried out. The column was on the move by the time he was brought in, so he had to be jolted in an ambulance over terribly rough roads the whole day till a late hour in the evening, when the column halted for the night. On arrival I found him so collapsed that operation was out of the question. His pulse, which was a mere flicker, and his deathly pallor suggested severe internal hæmorrhage, but to my surprise I could find no dulness in the flanks. I learned that some friend, not knowing that there was any danger in doing so, had given him some brandy shortly after he was hit and that this had caused intense pain. At the time of arrival in camp he complained of no pain, though the journey had tried him terribly and had necessitated hypodermic injections of morphia. All that could be done in the few hours

we had before our start again at daybreak was to apply stimulants in the form of warmth, brandy and milk by the rectum and occasional hypodermic injections of strychnine.

War is not a pleasant thing at any time, but one realises some of its horrors when one has to start a man in such a condition upon another long journey of agony ; but a merciful Providence put an end to his sufferings before we had gone many miles.

My own conviction with regard to this case is that this patient died of shock and that the fatal termination was accelerated by a certain amount of local peritonitis set up by too early administration of brandy by the mouth. The intensity of the shock was due, in my opinion, to the proximity of the wound to the solar plexus and was of course intensified by the severe strain of the journey. From the direction taken, the bullet ought to have wounded the right kidney, but there was no hæmaturia or other evidence to indicate injury of this viscus ; but then I had not seen many wounds caused by the modern bullet before coming to the conclusion that it was practically impossible to judge with any accuracy the nature of internal injuries from the apparent direction taken by the bullet. For example : in one case a bullet entered close to the left articulation of the jaw and emerged close to the right side of the cervical spine. One naturally concluded that it must have perforated the trachea and œsophagus, to say nothing of many other more or less vital structures, yet there was no dysphagia, no dyspnoea, no hæmatemesis, or indeed any urgent symptom. All the man complained of was a slightly stiff neck and some *soreness of the gluteal region*, which had been grazed in the downward course of the bullet. But, to return to the point at issue : my opinion with regard to the cause of death in this instance was strangely borne out in the following case which, unfortunately, I did not have under my own care.

Owing to our column having to send on a detachment at one time to occupy temporarily the town of Senekal, I had to detail two medical officers to accompany it, taking with them sufficient equipment to allow of their forming a temporary hospital in that town for a few days, as it was



arranged that our main column would join them later. The medical officers I chose for this duty were both civil surgeons, they were men on whom I could thoroughly rely, and one of them in particular was a very capable operator.

On their march they were attacked and an officer of the Yeomanry was wounded. The bullet in this case was found to have perforated the epigastrium apparently in much the same position as in the case previously described; it had passed out at the back close to the spine, but I cannot say on which side, as my notes on this case were lost. Owing to his collapse, severe internal hæmorrhage was diagnosed and it was decided that laparotomy was justified, as it could be performed under a roof, and there was reason to hope that he could be given complete rest, at any rate for a few days after the operation. The only available house was by no means ideal for the purpose, for it had been evacuated for many months, was full of dust and sadly needed airing. Still, it was the best to be had, and the case admitted of no delay if it was to be operated on at all. On opening the abdomen in the middle line it was found that there were two perforations through the stomach-wall and that a small artery in the omentum was bleeding. There was, however, absolutely no other sign of hæmorrhage, and the artery in question was too trivial to need ligature, though one was applied. The gastric wounds were sewn up and the abdomen closed, but the man only survived a few hours. What, then, was the cause of his intense collapse and subsequent death? I am myself fully convinced that it was due to shock, consequent, as in the other case, upon the juxtaposition of the bullet track to the solar plexus. But if this was so, the importance of its recognition in future cases cannot be over-estimated, for it is at once apparent that the one hope of recovery under such conditions will be lost if the abdomen is opened and the existing collapse intensified thereby. Who shall say that this man might not have recovered if no operation had been performed? For he had the advantage of absolute rest, which is so essential to recovery in these cases.

Judging by these two examples, I naturally came to the



conclusion that wounds involving the stomach were of an extremely dangerous character, and it was with surprise that I found that Mr. Makins regarded them as favourable. However, I found that he based his opinion on the two cases that came under his particular notice. The direction taken by these bullets in these cases was as follows:-- One from an entrance wound in the ninth left intercostal space in the posterior axillary line to its exit close to the left of the xiphoid appendage; the other from an entrance in the eighth intercostal space three-quarters of an inch from the spine to its exit through the seventh left costal cartilage. The first of these cases recovered without operation. The other was fatal after operation, but in Mr. Makins' opinion would not have been so had it not been necessary to keep open the external wound to allow of the escape of abundant foul discharge from the liver, which was involved,

From the above description it is clear that the tracks of both these wounds were considerably above those in my two cases, and this, I consider, accounts for the fact that no mention is made of their having been attended by severe shock.

Mr. Makins records other cases of stomach wound which were reported as favourable, but these did not come under his direct notice, so that he does not describe the position of the tracks.

Colonel Stevenson, in his book on the subject, merely gives statistics showing that stomach wounds were favourable, but does not describe any particular cases, so I have been forced to draw my conclusions from those I have just detailed. Nevertheless I think my two cases are sufficient evidence of the point that *there is danger in acting upon the assumption of internal hæmorrhage, based upon the intensity of the collapse, in antero-posterior wounds of the upper abdomen*, when the symptoms are in reality purely nervous in origin.

Much controversy has raged round the question as to whether explosive bullets were used by the Boers, but this has been denied by most authorities. By "explosive bullet" I mean a bullet that has an explosive charge in it. Explosive "effects" as the result of bullets which had been tam-

pered with were by no means uncommon, and some such effects were produced by an ordinary small-bore bullet, splintering a large bone and transmitting some of its velocity to the fragments, which by being thus forced through the limb produced wide destruction of tissue, but the following case is not explainable on either of these hypotheses.

The man was a trooper in the Royal Scots Mounted Infantry. He had been wounded whilst on outpost duty, and was brought to me in a condition of extreme collapse. He could nevertheless manage to answer a few questions and explained that he felt no pain. I found that he had received three wounds. The largest was a surface wound, running transversely across the chest and epigastrium at the level of the sixth left rib at the junction between it and its cartilage. It measured about 5 ins. by 2 ins., and mainly consisted of a superficial denudation of the skin, except at one end, where the impact of the projectile had broken the rib and thereby torn the pleura, through a small opening in which could be heard the whistling of air. To account for his critical condition, I searched for signs of hæmorrhage into the pleura, but was surprised to find both pleuræ resonant. Then I examined the wound for signs of perforation of the abdomen, but could find none, and the abdomen itself was not distended; so I turned to the other wounds. I found that a bullet had entered the left thigh on its outer aspect, at the junction of its lower and middle thirds, and after shattering the femur into numerous fragments for about 3 ins. of its extent, had emerged by a large gaping wound at the inner side of the limb, at a point in a direct line with the femoral artery. A rough tourniquet had been applied above the wounds, but there was still a good deal of oozing going on. I naturally concluded that the femoral artery had been pierced and that his condition was consequent upon loss of blood from this vessel, but was again non-plussed by finding, when I cut down on the artery in hunter's canal, that it was intact. Before more could be done the man expired. No significance attached to the third wound, as in this case the bullet had merely penetrated the soft structures of the right thigh. Fortunately I was able to make a rough

*post-mortem* examination, and this was productive of most surprising results. Having again examined the first wound for signs of perforation into the abdomen without result, I opened the abdomen at this spot. My first discovery was an almost invisible puncture in the œsophageal end of the stomach, which evidently could only have been caused by a minute fragment of metal, and round this perforation several minute particles of metal were imbedded in the stomach wall. This organ was otherwise intact, so I passed my hand along the under surface of the liver to discover a huge fissure, traversing the entire extent of the left lobe, and passing into the right lobe for nearly half its extent. On removal of the organ, I found that the fissure formed a *cul-de-sac* in the right lobe, at the bottom of which was another small piece of metal no larger than a millet seed. These were the only pieces of metal I could find in the man's body, although I made as careful a search as was possible under the circumstances.

I can only account for the effects just described by supposing that a large explosive bullet struck the rib and burst, and that the little pieces of metal made their way into the abdomen by invisible holes, the liver itself having been split by concussion. A pom-pom shell, similar to that on the table, might split an internal organ by merely grazing the surface of the abdomen, but I ascertained that no shells were being fired at the time, and, in any case, this would not explain the presence of the tiny fragments of metal which were evidently not shell-fragments.

The only other evidence I have pointing to the use of explosive-bullets of some kind by the Boers is that on one occasion, when our column was on trek, and was, as usual, being sniped at long range by our invisible enemy, I heard a sudden report behind me, apparently coming from the ground. As I turned, I saw a trooper's horse close to where the sound came from rear up on its hind legs. The only explanation was that an explosive bullet had struck the ground in front of the animal; the trooper himself being convinced that this had been the case. The report, though much louder than that of a discharged rifle, was not so loud as that of an ex-

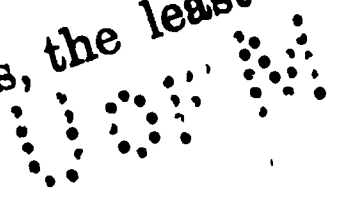


The next slide illustrates a symmetrical perforation; the upper figure shows the aperture of entry, which is surrounded by ecchymosis and is roughly circular; through it a ring of mucous membrane protrudes and partially closes the opening. In the lower figure is seen the aperture of exit in the form of a curved line which is also occluded by mucous membrane. The same amount of difference in the characters of the entrance and exit wounds does not always exist, for in many cases both were found to be circular. Three apertures in close proximity have been seen, one of them being no doubt due to lateral impact. In the next slide is seen the same piece of intestine viewed from within; the localised ecchymosis is here well seen, it being more extensive owing to the blood spreading more readily in the submucous tissue. The two indicating lines lead to the openings, which appear slit-like and are sunk at the bottom of folds.

Many cases, some days after the receipt of the wound, develop local peritonitis with abscess formation, the pus requiring subsequent evacuation, but this sequel, although comparatively common in cases of perforation of the small intestine, and because Mr. Makins saw no cases in which abscess formation followed perforation of the small intestine, he argued that these wounds must be far more fatal, but might it not be that wounds of the small intestine have less tendency to set up purulent formations. I do not consider that his evidence is sufficient to justify him in considering perforating wounds of the small intestine so fatal, but bullets traversed the small intestine area and the patient recovered without local abscess formation, that no perforation of the small intestine occurred.

A very remarkable case was published by Mr. Watson-Cheyne in the *British Medical Journal* in which a spent bullet caused rupture of the small intestine in two places, although it had not perforated the abdomen. Such an accident must be extremely rare, and I doubt if it was the result of a small-bore bullet.

As to the prognosis of abdominal wounds, the least dan-



gerous cases were found to be those in which the bullet crossed the abdomen obliquely from the anterior wall to the flank on the same side, or from flank to loin on the same side. Those from the upper part of the loin to close to the anterior superior spine of the ilium on the same side were also favourable.

My experience leads me to consider bullets crossing obliquely from one loin to close to the opposite anterior superior spine as favourable, and this is borne out by a similar case recorded in the Portland Hospital reports, which recovered without operation.

The dangerous wounds were those crossing from flank to flank, especially when the wounds were situated between the eighth rib in the mid-axillary line and the crest of the ilium; above this level, the liver or liver and stomach were sometimes alone implicated and the cases did well; the false pelvis was frequently crossed without any viscera being injured. Antero-posterior wounds in the small intestine area were found to be very fatal when the course was direct.

One fact of very great importance which was observed by Mr. Makins was the fatal nature of extraperitoneal wounds of the large intestine, every case which he saw having died.

So far as *treatment* is concerned, I think I have made it fairly clear that immediate operation under war conditions is very rarely justifiable, and in civil practice I think there should be no hurry to operate on cases in which the direction taken by the bullet is one of those which I have indicated as favourable. On the other hand, in such cases as wounds from flank to flank, and direct antero-posterior wounds of the lower abdomen, immediate operation would give the patient the best chance, seeing how fatal are such wounds if left alone. In those cases where the posterior aspect of the colon is involved, the wound should be freely opened and the bowel either sutured or fixed to the surface, free drainage being provided afterwards, for it seems pretty clear that if this is not done that septic infection will carry off the patient.

It is strange that both Colonel Stevenson and Mr.

W. H. L.

Fig 5.

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Makins, in the only two books dealing with this subject, dismiss the question of the dieting of these patients with but a few words. Thus, all that appears in Mr. Makins' book is the following: "When feeding is commenced at the end of twenty-four or thirty-six hours, it must be in the form at first of warm water, and then milk, administered in teaspoonfuls only." This is all very well as a broad working rule, but it would not do for every case, as cases differ so much from one another. In my opinion, each case should be judged on its own merits, and the dieting carried out accordingly. It is so essential that the patient's strength should not be allowed to run down too far, that the question as to how soon food may be given is of the greatest moment. For example, where a man is shot at the end of the day, after he has been going through a great deal of physical exertion, and has had no food since the morning, he will probably be found in an extremely exhausted state, and one would not feel justified in delaying the administration of nourishment for longer than was absolutely necessary.

It seems to me that the position of the wound is an important guide to one in judging how soon and in what way food should be given. Thus, if the wound is low down, and probably involves the large intestine (as in the first two cases I described), I do not consider one would be running any great risk in giving teaspoonfuls of milk every hour and, later on, every half hour, commencing twelve hours after the receipt of the wound. This I did in the second case I have described, and the man suffered no ill effects. In cases where the stomach is wounded, and there is no reason to believe that the transverse colon is also involved, I cannot see why nutrient enemata should not be begun in a few hours, if urgently needed, whereas it would be most dangerous to begin food by the mouth in twenty-four to thirty-six hours.

I have had the next slide (fig. 5) made from a skiagram I made at Gibraltar with one of the first instruments issued by the Government. The man was cook to the Grenadier officers' mess. He had been a butler many years before, and had one day made investigations into the working of his master's gun. A large number of shot were removed at the

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time and the hand had healed up. Ever since that time he had been doing his work without the slightest inconvenience, except that latterly he had noticed two lumps near the thumb which were tender. He thought they might be shot and so came to me to remove them for him. The rays discovered thirty-three shot altogether, much to his surprise. Needless to say I did not disturb them.<sup>1</sup>

<sup>1</sup> Numerous other photographs illustrating the damage to bones caused by the modern bullet, as well as veldt scenes, were exhibited by Dr. Cooper, but unfortunately lack of space and other circumstances did not permit of their reproduction.—ED.

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## ON CHORIO-EPITHELIOMA.

A COMPILATION BY EDWIN A. NEATBY, M.D.

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[The basis of this address was 'originally prepared for the post-graduate course delivered at the London Homœopathic Hospital, and was subsequently presented in a modified form, with lantern illustrations, to the Liverpool Branch of the British Homœopathic Society. It lays no claim to originality, being compiled from recent literature of the subject in English and German. In great part it is a summary of a very complete treatise on the subject by Dr. Teacher, of Glasgow, which appeared in the *Journal of Obstetrics and Gynæcology of the British Empire* for July, 1903.]

THE main object of this communication as a post-graduate lecture was to trace the histological connection between the physiological tissues and processes involved in the early development of the human ovum and the tissues and processes demonstrable in the malignant growth.

Lest the length of the name and the original obscurity of the subject should deter some from commencing to read this paper, let me say at the outset that the study of the subject has proved to me one of the most fascinating that I have ever undertaken. If the setting forth fails to engage the reader it is not because of want of intrinsic interest in the subject.

To impart something of individuality to the disease we will, before entering into considerations of pathology and pathogenesis, go over the clinical features. In the first place chorio-epithelioma is a malignant disease which arises in almost every instance in association with pregnancy, either normal or abnormal. Most frequently of all it follows upon hydatidiform mole. Next most frequently it is associated with abortion, after that with normal delivery, and last of all with tubal pregnancy. In the last-named cases its rarity is only absolute, owing to the happily comparative rarity of ectopic gestation.

The time at which the symptoms begin to arise varies from a fortnight *after* the confinement or abortion, to about a year. Though the obscure cell changes which lead to the disease may have commenced during the presence *in utero* of the foetus or mole, no evidence of its existence becomes manifest until after the termination of the pregnancy.

Entering now into detail as to the symptoms, it will be seen that they bear a close resemblance to those of ordinary uterine carcinoma, but that the worst features of that grave malady are here all exaggerated and emphasised. In the first place the hæmorrhage occurs early and comes on both suddenly and severely. It is usually of a bright arterial character and is frequently repeated. Even where hæmorrhage has not taken place spontaneously, it may be readily excited by any form of manipulation, especially by an attempt to curette. So pronounced is this feature that the patient's life may be at once placed in jeopardy by a single hæmorrhage, and if this does not occur, repeated losses rapidly induce exhaustion. In the intervals between the hæmorrhages there commonly occurs a free discharge, thin, acrid, blood-stained and offensive. This is associated with fever and rigors. It is probable that these last symptoms are due more to the development of a septic condition than to the growth of the tumour itself. The tumour rapidly breaks down and retained necrosing particles give rise to the cachexia which rapidly develops.

Another important and not very infrequent symptom is that of hæmoptysis. This is sometimes the very first point to attract notice, and may cause the attention to be diverted

from the pelvic sphere to the lungs. It is due to a true metastasis of the growth. The hæmoptysis forms an exception to the statement I made earlier that these symptoms correspond with those of ordinary uterine carcinoma. To prevent mistakes and the loss of valuable time, hæmoptysis or other chest symptoms not usual to the patient should be borne in mind as possibly having a pelvic origin when occurring within measurable distance of a pregnancy.

Next in importance comes the tumour itself. It frequently happens that on the very first examination a tumour of considerable size is found in the uterus or in the vagina. After its removal by partial operation it frequently redevelops in the space of a few days with amazing rapidity. The growth differs in appearance from most other forms of cancer in being more spongy and friable; it may resemble retained placenta, or even more frequently it will be like old blood clot, of a dirty brown or brick-red colour. Sometimes no uterine tumour is found, but examination reveals a growth in the vaginal veins or the veins of the parametrium.

In spite of the existence of these well-marked symptoms there may be some uncertainty about the diagnosis; for, although a patient should seem to be in an almost hopeless condition, it may happen that the removal of the growth is followed by an entire cessation of the symptoms and complete recovery. It therefore becomes extremely difficult to determine whether a radical operation should be performed or not. It is obvious that it is better to operate several times in uncertainty than to allow one case to die unaided. Where the clinical evidence is confirmed by the microscope no time should be lost, and if there is a discrepancy between the two, the clinical evidence should rank before the microscope.

Much discussion has taken place with regard to the nature of this growth. The first case to attract attention was reported by Saenger, under the name of deciduoma malignum, a name which is still occasionally used in a clinical sense. His view, and that accepted until 1903 in this country, was that it is a sarcoma already existing in the uterus at the time of conception, and that the growth and

character have been modified by the pregnancy. It is now known that it takes its origin from the foetal epiblast. It must therefore be classified as an epithelioma, but it remains true that its habits are much those of a sarcoma, for it is spread by the blood-vessels and not, to any appreciable extent, by the lymphatics. Lymphatic affection is very rarely found, and when it is present it is probably due to septic absorption and not to tumour invasion. Lymphatic glands may, however, become involved in the growth of a tumour, attacking the glands from the outside, and this is especially true in the case of metastatic deposits, for instance, in the lungs, where a growing mass may spread to the mediastinal glands.

The natural progress of these cases is towards death, but in a small proportion of cases spontaneous recovery has taken place; in these cases, of course, a question may arise as to the real nature of the case. In a considerable number of cases (53 per cent.) recovery after a radical operation has taken place.

The causes of death are hæmorrhage, exhausting discharges, sloughing of the tumour, rupture or perforation of the uterus and metastasis in other organs.

The treatment hitherto has been mainly operative, and where the clinical and histological evidence are both in favour of chorio-epithelioma, radical measures should always be promptly carried out.

We will now turn to the related physiological points. Actively-growing and young cells undergo an elaborate series of changes prior to their division, known as karyokinesis. All the investigations which have hitherto been made by the Cancer Commission to discover the cause of malignant diseases have shown that some intimate changes in the segmentation of cells appears to be associated therewith. This form of segmentation, or "indirect division," is found in the large cells which are a conspicuous feature in chorio-epithelioma.

The ovum is originally a mononucleated cell and it divides like other cells in the beginning; after fecundation has occurred segmentation proceeds more rapidly, and in a

more complex manner. All we are concerned with here is the fact that two layers of cells become differentiated from the rest, an inner and an outer layer. The outer cells become large and cubical, and at one point they undergo a considerable thickening. At this point it is that the ovum attaches itself to the uterine wall, and this part comes to be called the chorion frondosum. These thickened cells project from the surface of the ovum in small, finger-like processes, which are at first solid. A drawing <sup>1</sup> (fig. 1) represents diagrammatically the condition of things at this stage. The outer layer of cells referred to becomes known as the epiblast or ectoderm, and the underlying smaller cells form, ultimately, the mesoderm. Some of these smaller cells gradually grow up into

FIG. 1.

Ovum measuring  $6 \times 4.5$  mm. *a* = amniotic cavity; *b* = belly stalk; *c* = chorionic villus; *e* = embryonic disc; *y* = yolk sac.

the finger-like processes and form a central core which early becomes the connective tissue and vessel-bearing element in the said processes, henceforward to be known as villi of the chorion. It is not known at what date of pregnancy in the human subject the villus first obtains its core of mesoderm cells. It is, however, very early, for I have seen a specimen, which will shortly be published, where a connective tissue core had already developed at what was nominally the third day of pregnancy. I say nominally, because although menstruation was only three days late the exact period of conception was unknown to me.

<sup>1</sup> After Spec. From McMurrich: "Development of the Human Body."  
With kind permission of the publishers.



What next happens is that the tips of some of these villi fasten themselves to the uterine wall in a quite peculiar manner to be described shortly. By means of these points of attachment, the nutrition of the ovum is carried on, and for this reason these cells covering first the ovum as a whole and then these specialised processes or villi have been termed the trophoblast, a convenient term now in general use. After a time, in the human subject, the trophic function is limited to the chorion frondosum, which together with the modified uterine wall becomes the placenta.

Figs. 2<sup>1</sup> and 3 show a more advanced stage of the embryonic and maternal circulatory apparatus. There are seen

FIG. 2.

FIG. 3.

Formation of villi. *Bl* and *Is* = Intervillous space; *ca* = capillary of uterus; *en* = endothelium of same; *fi* = fibrin; *M* = chorionic mesoderm forming core of *V* = villus; *sp* = spongy decidua; *Sy* = syncytium; *Tr* = trophoblast.

fully formed villi—vascular processes, some of which form an attachment to the uterine wall, while others float free in the intervillous space, washed by the maternal blood stream.

The next step to be considered is the embedding of the ovum. I may remind you of the view held till recently, that when the fertilised ovum enters the cavity of the uterus it settles down quietly on the mucous membrane, which grows up all round it until the ovum is entirely covered by or embedded in the mucous lining of the uterus and the mucous membrane receives different names at different points.

<sup>1</sup> After Peters. From McMurrich: "Development of the Human Body."  
With kind permission of the publishers.

Where the ovum settles is called the decidua serotina, that part which grows up round the ovum being called the decidua reflexa, and that of the rest of the uterine cavity the decidua vera. Recent investigation shows that alteration must be made in the description of the embedding of the ovum. Instead of it resting on an intact mucous membrane which grows up all round it, it will be seen in the figure (fig. 4)<sup>1</sup> that the epithelial lining is wanting. Where the ovum has settled the cells have disappeared, and the deeper part of the ovum lies in direct contact with the connective tissue.

Much discussion has taken place as to whether this occurs as it were by chance, the ovum finding itself upon the spot already denuded of the mucous lining by menstruation, or whether the disappearance of the epithelium is due to a distinct aggressive erosive action.

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the uterine wall the orifice is closed by mucus or blood-clot, and later by the regeneration of the epithelium itself. But at no time is the epithelium replaced at the deep surface of the ovum, so as to cause it to lie in a nest or envelope of epithelium. At this stage, therefore, the ovum is fully embedded; it is lying actually within the uterine *wall*, beneath the epithelium and not free in the cavity of the uterus. A distinct scar may for a time be seen at the spot where the ovum first rested and destroyed the epithelium. These points have been settled, as regards the uterus, both by English and continental writers. In tubal pregnancy they may be occasionally demonstrated with equal clearness. At an early date the gestation sac may be seen lying wholly in the tubal wall, not occupying the lumen at all.

<sup>1</sup> After von Spee. From Teacher: "On Chorio-Epithelioma," *Jnl. Obst. and Gyn. of Brit. Emp.*, July, 1903. By kind permission of the author.



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**FIG. 6.**

**Compact decidua.** *A* Large connective-tissue cells have crowded out the glands. Clear protoplasm, well defined in regions, large nuclei and nucleoli; *B* Tear; *C* The decidual cells on this side are faint and obscured by much small cell infiltration.



FIG. 7.

Spongy decidua. The large cells are only faintly outlined at *A*; *B* Lumen of dilated glands; *C* Other glands in section, showing lining of columnar epithelium. Inflammatory cells scattered about.

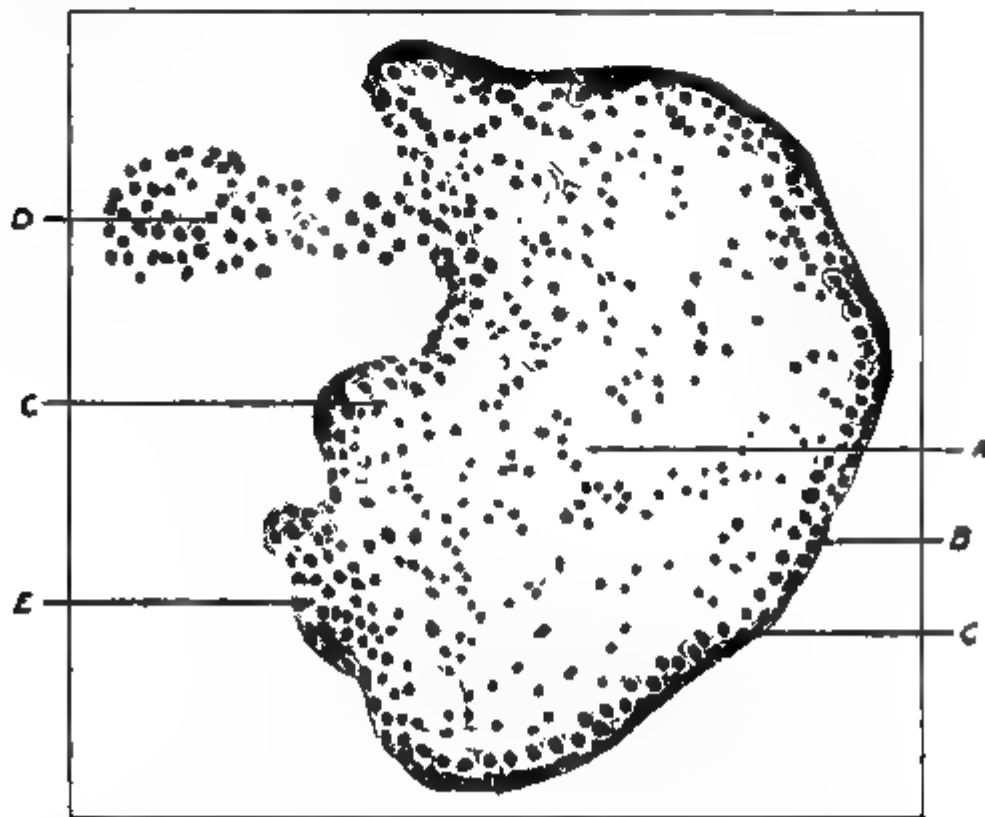


FIG. 8.

Cross section of young villus. *A* Mesoblastic core; *B* Syncytium; *C* Langhans' cell layer, "individual" cells; *D* Syncytial "bud," with some individual cells in centre; *E* Clump of cells (trophoblast).





The stimulus or irritation of pregnancy extends far beyond the epithelial lining. Again the Fallopian tube serves as a useful illustration. Burrowing into the tubal wall the ovum sets up inflammatory reaction, the fibrous tissue swells up and the cells become large and oedematous and take on the appearance of decidual cells. Indeed, it is stated that this effect may spread even beyond the wall of the tube; recent German authors have described decidual changes in adjacent and adherent structures, such as the appendix vermiformis and the omentum.

Fig. 5, taken from one of my own slides, shows the tubal wall in a case of ectopic pregnancy, with the villi penetrating among the muscular fibres of the tubal wall, and reaching in one part very close to the peritoneal surface.

The first change which takes place in the uterine wall is increased vascularity, with thickening and elongation of the uterine glands. The superficial portions remain comparatively straight, though they grow larger and longer. Their middle portion is dilated and tortuous, whilst the deepest portions are tortuous but not dilated. This thickened superficial portion of the mucous membrane is called the compact decidua; while the deeper part is called the spongy layer of the decidua. Fig. 6 shows compact decidua, with its large flat cells and one or more nuclei; the spongy layer is figured in the following slide, No. 7. In fig. 6, to the right of a laceration in the section, the decidual cells are almost obscured by a vast number of small inflammatory cells.

Sections of large dilated glands lined with epithelium, forming, with the vascular connective tissue the spongy layer, are seen in fig. 7. It is at this level that the separation takes place after delivery; the large glands assist in making a kind of demarcation line, like the perforations of a postage stamp. Between the glands in the compact layer a number of large connective tissue cells with one or more large nuclei appear, and these grow to such an extent that very often the glands are squeezed out of existence and even the columnar epithelium of the uterus itself disappears. How different is the spongy layer can be seen in the next drawing (fig. 7), where the wide glandular tubes are

seen cut across in varying directions. In some of these the epithelium has disappeared, but in the majority it is well preserved.

In addition to these glandular changes, the vessels of the uterine wall increase in size and also in number. The new vessels are thin-walled, especially in the mucosa and sub-mucosa. They readily rupture, either spontaneously, from the heightened vascular tension, or as the result of the erosive action of the cells of the trophoblast. Maternal blood is thus effused and fills the intervillous space, the villi which are not attached to the connective tissue waving free in the blood stream of the maternal circulation. It will be thus seen that there is no commingling of the foetal and maternal blood currents.

It is now necessary to retrace our steps somewhat, and consider in a little more detail the epithelium of the villi. The prototype of the various cells which are found both in hydatidiform mole and in chorio-epithelioma is seen in the layers of cells covering the normal chorionic villus in the early months of pregnancy. The next drawing (fig. 8), which shows a cross section of a villus, is one of the most important of the series. The striking feature about this is that the two layers of cells differ widely in character one from the other. The outer layer is called the syncytium. Strictly speaking, the epithelium is not divided up into individualised cells, but is a continuous line of protoplasm with a large number of nuclei one or two deep. The protoplasm mass stains deeply, and the nuclei are comparatively small and deeply staining. The syncytium, shown as a marginal strip, also exists as processes or outgrowths, called "buds," which may either float in the maternal blood of the intervillous space or may become detached and lead an independent life nourished by the blood directly. A portion of this living cell mass may be washed into the open mouths of the uterine vessels and, adhering to the sides, may rapidly proliferate, so that long strings of it extend an indefinite distance in the veins of the mother.

The inner layer is, in all its features, so entirely different from that described as to form a direct contrast to the

syncytium. The cells are large and so well defined that they are called the individual cell layer, or, more shortly, Langhans' cells, after their first describer. These cells are filled with clear cytoplasm, with large vesicular nuclei which do not stain deeply, and which are found to contain glycogen. The syncytial nuclei, on the contrary, are solid, and they contain fatty particles. These cells are derived from the ectoderm. In addition to these two well-marked varieties, there are a number of mixed or intermediate cells, which are found mainly at the tips of the villi, especially the villi of attachment. These cells penetrate as "wandering cells" into the connective tissue and muscle of the uterine wall.

The foetal structures are united, as we have seen, to the maternal by the villi of attachment. The intermediate cells multiply and form a thick clump at the tips. The cells of these clumps, or knots, as they are often called, are very actively-growing cells. Their presence is associated with a remarkable change in the uterine wall immediately external to their insertion. A broad band of pale, almost hyaline structureless character intervenes between the well-defined villi and the well-defined uterine tissue. This is a layer of fibrin, which is supposed to be thrown out as a protection against the aggressive action of the trophoblast. It is called the fibrin layer of Nitabuch (see fig. 9). It is noticeable, however, that, in spite of the protective effort of the fibrin layer, many cells penetrate inwards past this barrier, and are found infiltrating the muscle and connective tissue of the uterine wall. From all that has been said, some idea of the active and aggressive nature of the cells which are engaged in contributing to the nutrition of the ovum will have been obtained. It is evident that, at this stage at least, it is truly parasitic in nature and conducts its operations with almost as much precision as might be expected of an intelligent being.

There is one point which has not yet been mentioned in connection with the behaviour of the villi of pregnancy which is of great importance, in view of the peculiar development of events in chorio-epithelioma. I refer to what has been described by Veit as the deportation of villi. It is believed

by that writer that portions of the smaller villi or of the epithelium covering may be washed off by the blood current and be transported into various organs of the mother, where they prove innocuous under ordinary circumstances. The maternal tissues in these cases show themselves quite equal to disposing of these protoplasmic emboli.

So far we have been occupied with physiological conditions, and, before proceeding to consider the departures from the normal which culminate in chorio-epithelioma, it may be well briefly to summarise the points already advanced. The epithelial covering of the villi of the chorion consists of two layers, an outer, where the cytoplasm is not differentiated into separate cells, where the nuclei are solid and stain deeply, and an inner, where individualised cells are large, well defined, and have vesicular nuclei, staining less deeply. The former is called the syncytium, and contains fat; the latter is the Langhans' layer, and the cells contain glycogen. Both these layers are derived from the ectoderm of the ovum, and from their nutritive function are together called the trophoblast. This name is especially applied to the heaped-up cell growth at the tips of the villi, which takes place chiefly in the villi of attachment, forming cell-clumps or "knots." From the syncytium outgrowths of protoplasm take place in the shape of "buds." The framework or core of the villi is fibrous tissue, with blood-vessels derived from the mesoderm. Some of the villi of the chorion come to be united to the connective tissue of the wall of the uterus at an early date, and the whole ovum lies buried in the uterine (or tubal) wall. Modified cells of the trophoblast wander off into the substance of the wall and penetrate between the muscular bundles and fibres. In addition to this, portions of syncytium or fragments of villi get washed off and carried into the maternal circulation. Detached buds or clumps may live and grow in the intervillous space. These facts are all part of a physiological process, whose evolution and involution are compatible with good health and a normal return to the unimpregnated condition.

The first departure in the direction of the disease we are considering is an oedematous condition of the core of the

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FIG. 9.

Uterine wall and "villi of attachment" *A* Syncytium covering a villus; *B* Clump of trophoblast at tip of villus—mixed cells; *C* Homogeneous or fibrin layer (Nitabuch); *D* Uterine muscle; *E* Wandering cells of trophoblast in muscle of uterus, penetrated beyond the fibrin layer.



FIG. 10.

Dilated villus of hydatidiform mole. *A* Empty cavity; *B* Fibrous wall; *C* "Buds" covering wall. Watson obj. 2 in., ocular 1.



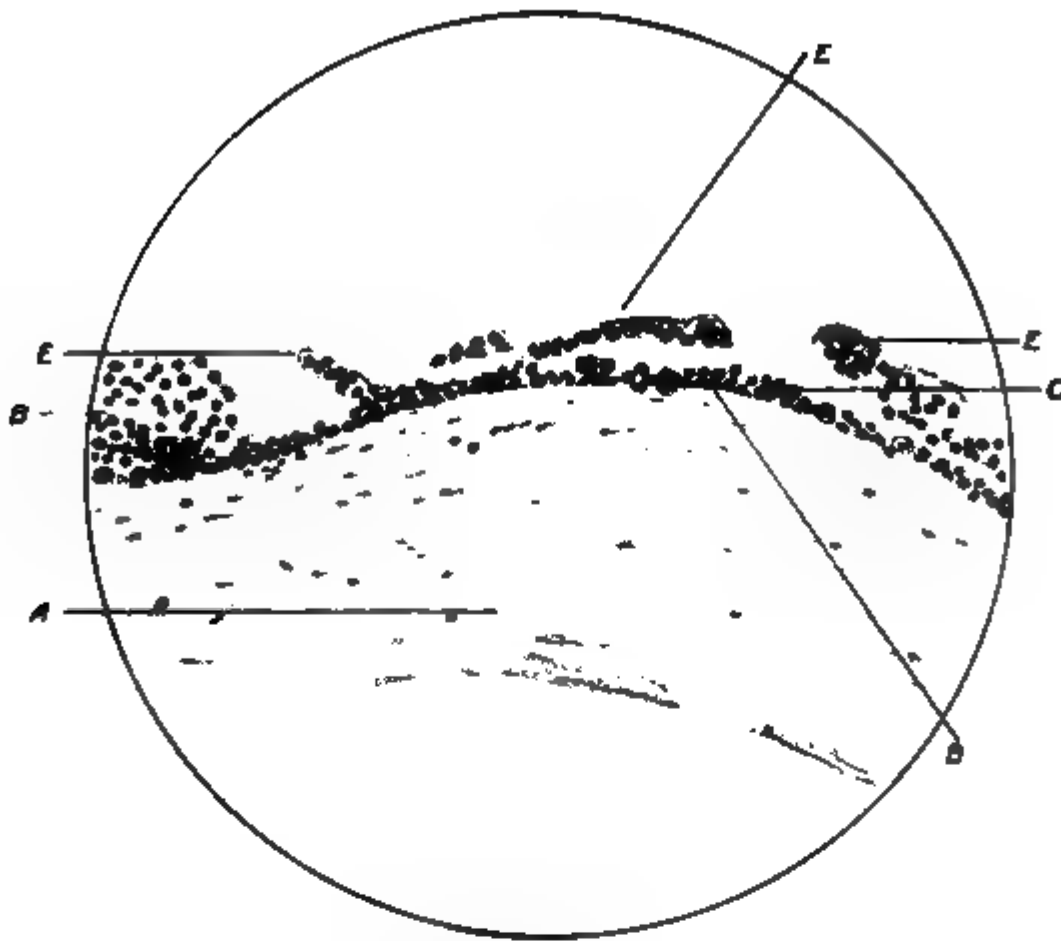


FIG. 11.

Wall of dilated villus (fig. 10) of hydatidiform mole. *A* Fibrous tissue; *B* Syncytium; *C* A few Langhans' cells mixed up with *B*.; *D* Clump of syncytial cells; *E* Buds of syncytial cells. Zeiss C., ocular 3.

B

A

FIG. 12.

Hydatidiform mole. *A* Langhans' cells; *B* Syncytium; *C* "Buds"; *D* Neumann's cells; *E* Blood clot in centre of villus; *F* Transition cells.





villus, a secretion of a watery fluid which distends the villus giving it the well-known currant-like appearance of hydatidiform mole. *Pari passu* with the degeneration of the core of the villus, an overgrowth of its epithelium takes place; sometimes only one layer undergoes hypertrophy, sometimes both. These changes are seen in figs. 10 and 11. The former of these is a section of a distended villus; the core has nearly disappeared, an empty space being left and a remarkable outgrowth of "buds" of syncytium has taken place. Under a high power (fig. 11), the buds are well seen with a few "individual cells" and a clump of trophoblast to the left. Here there is no overgrowth of the Langhans' layer. In the next figure (fig. 12) are seen the tips of three adjacent villi of a hydatidiform mole. On the left of the fissure, (space between the villi) is seen a heaped-up mass of large "individual" (Langhans') cells; these have broken through the syncytium, which is seen near the connective tissue core with two rows of nuclei. At the top of the fissure is the end of another villus where the cells are mainly syncytium, some intermediate cells being also present. On the right side is a villus with a covering of only a thin layer of syncytium, except on the lower part, where a number of buds and a "clump" are present. This villus is only beginning to be distended, as seen by its small central space and its thick, fibrous stroma. A considerable effusion of blood has taken place in its interior, the end only of the clot being visible in the drawing, and indicated by an area of fine dots. In this villus are some large cells in the stroma, showing large nuclei and well-marked karyokinetic figures. These are cells described by Neumann and called by his name. They were originally supposed to pathognomonic of malignancy, but it is now known that they occur in many non-malignant conditions, and they are not now regarded as in any way diagnostic. In fig. 13 another portion of one of these villi is shown, where the Langhans' cells have broken through the syncytial layer, pushing part of this before it,—see the dark nuclei at the lower edge of the drawing.

The histology, then, of hydatidiform mole consists in cystic dilatation of chorionic villi with an irregular overgrowth of

one or both their epithelial layers. This overgrowth runs wild to such an extent that the mole as a whole is larger than a normal ovum, date for date. The nutritive function, however, of the villi is interfered with, and the embryo dies early and the mole is expelled. Wandering cells invade the uterine wall to a larger extent than normal and render it soft and more liable to rupture or to perforation by an instrument or by the finger, should the delivery of the mole require artificial aid.

Here the atrophy of the connective tissue is accompanied by a true new growth of epithelial nature, sufficient to destroy the life of the parasite (ovum) but not that of the host, (mother). In other words, it is not malignant in the technical acceptance of the term. There is no independent proliferation of the wandering cells, encroaching on and destroying the normal maternal tissues. Malignant hydatidiform mole has been described, but it is indistinguishable, histologically, as far as I am aware, from chorio-epithelioma.

The next stage in the departure from the normal is where the trophoblast cells have not only hypertrophied and wandered, but where, having wandered, they seem to be endowed with an independent vitality, growing in the tissue they have invaded and at its expense. As in hydatidiform mole either layer may predominate, though the syncytium is perhaps more commonly in excess. The cells have a peculiar affinity for blood-vessels, in and around which they grow excessively. Having eroded blood-vessels they live in and feed upon the effused blood and the cells of the tissues, than which they have a more robust vitality. An example of how these cells develop in the interior of a blood-vessel is seen in fig. 14. This drawing, however, is taken not from a chorio-epithelioma, but from the section of a pregnant tube which is shown in fig. 5. This is shown magnified 180 diameters.

A typical section of chorio-epithelioma is to be seen in fig. 15, where the invading tissue is mainly syncytium. In the following drawing, fig. 16, a very special feature of this morbid growth is delineated, namely, its excessively hæmorrhagic character. On all sides of the cells is effused blood.

**FIG. 13.**

**A** Syncytial layer (from hydatidiform mole); **B** Displaced cells of syncytial layer; **C** Proliferating mass of Langhans' cells; **D** Break in syncytial layer occupied by cells of **C**.

**FIG. 14.**

**A** "Individual" (Langhans') cells growing on wall of vein or lymph space. (From wall of tube in case of tubal gestation, fig. 5.)



C

A

FIG. 15.

Chorio-epithelioma from uterine tumour. *A* Nest of degenerating syncytial cells, surrounded by thick envelope of small cell infiltration; *B* Uterine muscle and fibrous tissue; *C* Cell "knots" or clumps (syncytium); *D* Transition cells. Inflammatory small cells scattered everywhere.

A

FIG. 16.

Chorio-epithelioma from deposit in vaginal wall. *A* Mass of transition cells, mostly syncytial, embedded in blood clot on all sides. The blood clot shows some individual cells growing in it.



Some of the single cells have persisted in the midst of the blood-clot, where they are shown larger and more darkly stained than the fibroblasts which are beginning to develop in it. It has been surmised that this extreme tendency to blood-shedding, if such an expression may be legitimately used, may be an explanation of the supposed spontaneous cure of some of the cases. The theory is that the outpouring of blood into the tissues is so considerable that the cells are cut off from their nutritive supply and therefore that they die. This is a possible result, if the tumour is thoroughly isolated on all sides by a very extensive hæmorrhage, but I cannot say that it appeals to me as a very likely thing. The vitality of the growing cells, and the readiness with which they thrive on blood, even when it has been effused, causes me to doubt the adequacy of this explanation of spontaneous cures. There is, however, no better explanation at present forthcoming. There is one point in favour of this simple theory which ought, perhaps, in fairness to be mentioned. The bulk of most of these tumours consists of blood-clot and the broken-down remains of tissue, old and new, so that necrosis of a considerable part of the growth actually does take place. The actively growing part—indeed, one might almost say the living part of the growth, is mainly at the periphery.

The extension by direct continuity is one thing, producing wide-spread local destruction. The metastatic extension is quite another thing, with other and less favourable prospects, and a course the nature of which varies as widely as the site of the secondary deposit. If the transported villus is arrested in the lungs, it grows and impairs the pulmonary functions mechanically and vitally; the increasing growth breaks down and threatens the life of the victim from septic pneumonia. Sometimes the migratory particles find their way to the brain, and more than one case has been reported where a case that promised well in all other respects, succumbed, after a brave fight, to pressure from cerebral hæmorrhage or the progressive growth of a chorio-epitheliomatous mass in the brain.

In yet other instances the secondary growths are due to the spreading, from the uterus to the vaginal or pampiniform

veins, of syncytial cell clumps. These are arrested in the smaller venules or they contract adhesions to the walls of the small veins and proliferate where they have become located. In many instances, on examining the vagina, a bluish streak, thought to be a thrombosed vein, is seen; this is found, on microscopic investigation, not to be blood-clot, as was supposed, but a mass of living cells, having the characters of syncytium. It may form a string extending as high as the diaphragm, attached only to the end nearest the uterus and waving freely in the blood stream ready to be washed off at any moment.

In some instances there is no uterine tumour whatever. What has taken place is that the normal deportation of villi has occurred from an apparently healthy ovum, and the villi, instead of being, as is usual, absorbed by the maternal tissues, have undergone proliferation in their new home. Still more strange is it that, though some degree of departure from the physiological standard has in such cases begun, it may be arrested and no evidence of malignancy show themselves. This curious phenomenon has caused some writers to describe a chorio-epithelioma benignum.

The recent researches on the corpus luteum have tended to throw some light on the etiology of the dire diseases we are considering. A few words only must suffice on this part of the subject. Professor Freankel, of Breslau, has come to the conclusion that the corpus luteum is the body which regulates menstruation and which secures the proper implantation of the ovum when fertilised. Co-incidentally Dr. Lockyer, of London, has discovered that in cases of hydatidiform mole and of chorio-epithelioma, there is an excess of lutein cells in the ovary. Many of these become displaced and are found scattered about in the stroma of ova which look entirely normal to the naked eye, in both the above named diseases. It is believed that the excess of lutein tissue in the ovum may in some way influence abnormal development of the impregnated ovum. To get a complete idea of this subject, as far as it has yet been worked out, the reader should refer to the original paper by Dr. Cuthbert Lockyer, in the January number of the *Journal of Obstetrics and Gynæcology of the British Empire* 1905.



Before bringing this collection of facts and opinions to a close, it is necessary to mention that there is one apparent exception to the original statement that all cases of chorio-epithelioma are associated with a recent pregnancy. It has been found that some tumours having similar microscopic characters may occasionally be discovered in distant organs, in subjects where there has certainly been no question of pregnancy. Such instances are furnished by growths which have been found in the testicle or in the mediastinum of a male subject. These cases are clearly teratomata, and though they may not be easy to explain, it is certain that they are on a different footing from the tumours we have been describing.

Instances are common and are easily understood, where the foetus is infected by one or other parent. It is less common that the parent (mother) should be infected by the foetus; but this also, if not so readily realised, is yet explicable through the independent influence of the male parent. In chorio-epithelioma we have a still more strange combination of phenomena: the foetus infects the mother and the mother succumbs while the foetus escapes; and yet the disease starts in a tissue which forms no permanent part of either organism, but is a temporary structure having a passing use as a nutritive and connecting medium, and destined to be thrown off and rejected as development proceeds. It is unparalleled and it is so far unexplained.

We have now practically accomplished the task we started out to perform. We have traced the tumour from its prototype in the normal epithelium of the chorionic villus by way of the molar formation to the fully-developed malignant neoplasm. We have seen how very closely the pathological processes imitate the normal reproductive methods.

In considering these facts we are brought very near to the mysteries of life, near enough to look on in wonder, but not to discern a solution. Starting with the trophoblast, we see it heaping up cell growth in an altogether prodigal manner; we see the ovum fastening itself like a parasite on the maternal tissues; we notice the protective

efforts made by those tissues against the invader; and again we observe, and the equilibrium becomes established, and the two organisms, the old and the new, emerge from the conflict unscathed. The pigmy hosts of "Wanderzellen" started bravely to the attack, they crossed the frontier, they established numerous outposts in the new and unexplored territory, but some unseen power stayed them and said, "thus far and no further" shall ye go.

Once again we behold a cell beginning its new career, a cell in all points resembling the former one, the issue of whose journey was so triumphant. To a certain point it follows the same pacific route, but its exuberant energy defies the wise limitations that nature seeks to place upon it. Wasteful of its newly-acquired powers it multiplies without rhyme or reason, without let or hindrance. It becomes exhausted by its very prolificness, choked by its own profusion. A wasted life, a defeated purpose, it is cast out. If the figure of the fight is reverted to, after enormous outlay of effort and accumulation of indefinitely multiplied forces, occupying boldly and riotously the land—now treated as an enemy's country—the invading power is foiled, rolled back, destroyed by its own lavishness and lawlessness. If we ask whence this strange development, this departure from the orderly and pacific march, if we look to see where the change set in which had so disappointing an issue, it is but an echo which answers and eyes we have but we see not. The mystery of life hidden in the cell protoplasm is too deep.

Yet once more we start from the selfsame point; with the same powers—at least, to all appearances the same—we begin the same journey, again to lose our way. We see the same riotous, lawless prodigality which before ended so disastrously for the invading forces. But here, either the attack is more relentless and the perverted energy more viciously aggressive, or, perchance the wise and well-directed opposition is wanting, the resistance feeble and faltering. Here the march ends in still deeper disaster, for it is not the aggressor who now pays the penalty of his unwisdom, but the attacked, the unoffending host, who is overtaken

by ruin and annihilation. If again we ask "why"? and "how"? we are still answered only by dumb silence.

We are unable even to discern, and still less able to gauge the infinitesimal yet infinite variations of the vital cell activities which out of apparently identically similar fragments of protoplasm will in the one instance evolve a new organism, without damage to the parent, and in the other will ruthlessly sacrifice either parent or offspring.

## SCLEREMA NEONATORUM.<sup>1</sup>

BY J. ROBERSON DAY, M.D.LOND.

*Physician for Diseases of Children to the London Homœopathic Hospital.*

Sclerema Neonatorum is so rarely seen in this country and having recently had a case under my care, I venture to bring the subject before you this evening in a brief communication.

### DISTRIBUTION.

It is met with almost exclusively in Lying-in Hospitals and is rare even in them. In Italy and France it is a far less rare disease than in this country. In America it would appear to be very rare also. Dr. Libman showed a baby six weeks old before the New York Academy of Medicine (section on pediatrics) on December 9, 1897, stating at the same time that he had only been able to find *eight* cases recorded in America. In Italy, however, 70 autopsies per annum appear to be on scleremic infants.

Crocker describes it as a very rare disease in England. It is also rare in Germany and Austria.

### DESCRIPTION.

It is a grave disease about which much confusion exists. Lodemann pointed out its resemblance to phlegmasia alba

<sup>1</sup> Presented to the Section of General Medicine and Pathology, January 12, 1905.

dolens. The various writers describe it as :—" A rare and exceedingly fatal disease." " A rare disease practically unknown outside foundling asylums and lying-in institutions, and is by no means common under any circumstances." " An extremely rare disease in this country." " A strange infantile malady."

Owing to this rarity of the disease and the few cases which have presented themselves for examination there were various descriptions, and no clear conception of what was meant by sclerema existed till Parrott, in 1877, clearly pointed out the distinction between this disease, which is a true *induration* of the tissues, and *œdema* neonatorum which is often confounded with it. This confusion arose in this way: Underwood first described sclerema—the real cellular-tissue induration—in 1781. But Andry subsequently transferred this description to the *œdema* of the new-born children frequently seen at the Paris Foundling Hospital, and which resembles the *œdema* of adult life, and is a symptom dependent on a variety of different causes. The characteristic signs are present, of which pitting on pressure of the finger is the most marked.

In sclerema, on the other hand, there is a true *induration* and *rigidity* of the skin over the greater part of the body, or in patches in certain parts only. In very severe cases the body appears as rigid as if it had been frozen.

This true induration of sclerema chiefly affects the new-born child which has been prematurely born, and is thin and wasted.

There are two varieties of true sclerema—(1) fat sclerema, (2) sclerœdema.

*Fat sclerema* is due to a solidification of the panniculus adiposus following on drainage of liquid from the body through diarrhoea and vomiting.

The fat of infants is richer in stearin and palmitin and poorer in olein, than is the case with adults, and therefore it solidifies at a higher temperature.

*Sclerœdema* is a peculiar form of firm *œdema*, due to serous infiltration of the subcutaneous tissues and of the connective tissues between the muscles.

These two forms are hard to distinguish. The skin is tense, hard, and adherent to the subjacent tissues, the joints are stiff and in severe cases the whole body may be cold, hard and stiff, like a body in *rigor mortis*, which can be lifted by taking hold of the head which is quite rigid with the trunk.

#### SYMPTOMS.

The symptoms come on when the child is a few days old, or in some cases are congenital. It is generally met with in the earliest days of life, although the disease may occur later and after the first month.

Cases have been recorded at  $4\frac{1}{2}$ , 8, 9 and 16 months and  $3\frac{1}{2}$  years.

An almost constant symptom is a fall in the body temperature; even the rectal temperature may register several degrees below normal.

The surface of the body feels cold, icy cold, as if frozen, and hence Usenbenzius, its first observer, described it as "Fœtus frigidus," like a corpse in winter.

The child is poorly nourished, and the digestion feeble.

The circulation is depressed, pulse weak and slow and may fall to 60. The respiration is similarly affected, being shallow and slow—10-14 per minute. This favours the development of pneumonia or bronchitis, which carries the child off.

The cry is so weak that Dorf Müller has compared it to "the squeak of a mouse."

The urine is scanty; convulsions are common.

The peculiar change in the skin begins in the lower limbs and spreads upwards, or in a few cases it begins in the face and spreads down. Hard patches appear in the skin which may spread, coalesce and become general. The patches in the cheek interfere with sucking and hasten the fatal end by inanition.

The skin is so hard and bound down to the subjacent tissues that it cannot be pinched up into folds. It feels like leather.

The tint of the skin may be normal, dusky or purple, or sometimes has an icteric tinge.

When the affected limbs are moved it causes pain. The joints are hide-bound and movements are very restricted or impossible. This was the condition in the case I shall presently read to you.

#### DIAGNOSIS.

The diagnosis is not difficult and in well-marked cases the appearances are so remarkable, that having been once seen are quite unmistakable.

The early age of the child, its premature birth, the emaciated condition associated with a very remarkably low temperature, the hard, cold, thickened skin, which cannot be pinched up into folds, and associated with this, feeble circulation and respiration, remove all doubt as to the disorder we have to deal with.

*Œdema neonatorum* has a similar low temperature, but the œdema has the same characters as in adult life, being most marked in the dependent parts, and the loose tissue of the eyelids, and on pressure of the finger, it pits in the well-known way. It is also the result of a variety of causes as in adult life.

In *tetanus* there is also a great rigidity of the muscles, particularly of the face; but the temperature is not sub-normal.

*Scleroderma* is hardly likely to be mistaken for it, being a disease of adult life and essentially chronic, although the affected patches of skin are indurated and may appear cold to the touch.

#### PROGNOSIS.

The prognosis varies according to the extent of the disease, the age of the patient, and the treatment employed. If this disease is general over the whole body it is very fatal, but if it is only limited in extent, the chances of recovery are greater.

## PATHOGENESIS.

Of the pathology; there is the syphilitic theory, the rheumatic, the inflammatory, the erysipelatous, the cardiovascular, the pulmonary, the hepatic and the nervous. All these in turn, according to Ballantyne, have been advanced as affording an explanation of this strange disease. All, however, are unsatisfactory and insufficient, and we must still regard the origin of this disease as unknown.

## TREATMENT.

Amongst the old school the treatment consists simply in keeping the patient very warm, and upward frictions of the affected limbs, with inunctions of warm oil. In our enlightened therapeutics, however, we have in the proving of Apis, a pathogenesis which exactly corresponds to the disease under our consideration. In the *upper limbs* the hands are bluish and inclined to be cold. In the *lower limbs*, cold legs, sensation in the toes and whole foot as if too large, swollen and stiff; feet waxy, cold, œdematous, numbness and coldness of the feet.

Further, there is a great debility, sensitiveness to touch and pressure; clonic and tonic spasms; weakness and coldness; apyrexia and scanty urine.

Such are the chief points of resemblance, and the selection of this remedy was fully justified by the result of its application.

*Two Cases from Recent Literature.*

*Case 1.*—Dr. C. Fox<sup>1</sup> showed an infant, ten months old, before the Dermatological Society with sclerema of the abdominal walls and buttocks. The patient was the twelfth in the family, full term, but small and wasted, till at three months the mother brought it to the hospital with what she called a “bladder” on the right flank. The abdominal walls were diffusely thickened, but there was no pitting. In a few weeks the skin became softer and the surface uneven, simulating nodulation. The “nodules” were really thinned areas of skin bulged out. The child recovered, but the treatment was not stated.

<sup>1</sup> *The British Journal of Dermatology*, January, 1904.

*Case 2.*—A case of sclerema neonatorum is reported<sup>1</sup> 7½ weeks old, the child born asphyxiated, had been delivered with instruments, and it was three quarters of an hour before it could be made to cry. It was breast-fed.

Two days before the mother brought the child to the hospital she noticed a "hardening of the skin on the neck and upper arm." On examination there was found "an induration of the skin along the entire back, from the neck to the coccyx, over the cheek bones, on the shoulders, on the sides of the chest, and the anterior aspect of the right and left femur." The skin in these parts was reddish-brown or livid in colour, could not be raised up in a fold, but there was no pitting on pressure. The joints were movable. The rectal temperature was 101° F. when first seen, which was remarkable. The child improved under treatment, which consisted principally in hot baths.

*Two Cases under Personal Observation.*

*Case 1.*—Child, 1 week old, admitted to the North-East London Hospital for children, November 27, 1904, under the care of Dr. Parkinson.

The child was born prematurely at the eighth month; a natural labour. Other children in the family quite healthy, and parents also healthy.

On admission both cheeks, eyes, and nose were swollen, with indurated patches of hardness; and similar indurations were over the spinous processes and on either buttocks. These swellings were livid in colour, cold and stiff to the touch. The temperature was subnormal (95°).

The child found so much difficulty in sucking, owing to the stiffness of the cheeks, that it was fed by a nasal tube.

The progress of the case was rapidly from bad to worse. On the patches on the cheeks and nose appeared bullæ, at first with serous fluid, then rapidly turning to pus, sanguineous and dark.

Respiration several times failed, and the child was restored by artificial respiration. On November 30 the child died. The only medicine given was Hydrargyrum cum cretâ.

I saw the child one hour *post mortem*. The hard masses of indurated tissue remained, deeply stained and superficially showing the black crusts of the bullæ, which had developed *ante mortem*. The body, though thin, was not specially emaciated.

<sup>1</sup> *Archives of Pediatrics*, November, 1904.



The temperature rose to normal before death, but never went beyond. I have to thank Dr. Swainson, the Resident Medical Officer, for his courtesy in allowing me to see this patient and read the notes of the case (Connaught Ward).

*Case 2.*—Florence M., aged 1 month, was brought to me at the London Homœopathic Hospital on October 26, 1904.

*Family history.*—Both parents healthy. Two other healthy children, except for one who has asthma. Patient is third in family, and was fed as an infant at the breast.

*History of present illness.*—When a fortnight old the feet and hands began to swell, also the eyelids and nose. After birth a very tight binder was applied, and this was pinned through the skin (by accident) in fastening it on. Mother attributes the swelling to this cause.

*State on admission.*—Patient presented a remarkable appearance. Limbs increased in size, dusky bluish leaden colour, cold and hard to the touch. The lower limbs were chiefly affected, especially the right, and the whole of right leg was considerably larger than the left. The right foot was dark purple. This hard swelling or solid œdema was well marked about the buttocks and nates, and especially the right labium. The dorsum of both hands was also swollen, hard, cold and purple in colour. The child was exceedingly cold to touch, and the skin of the affected parts presented the characteristic hard, leathery feel; it was impossible to pinch up the skin in folds. The tissues felt firm and solid. The right leg, which was most affected, was kept motionless, and was almost immobile, owing to the hardness of the tissues. Any movement caused pain.

The rectal temperature was 96·4°. The tongue was furred, and the child appeared feeble and ill. Apis 3x m i. every 2 hrs. was given, and directions to keep the child warm with hot bottles.

November 3. — She came again decidedly better. Rectal temperature, 97·8°, and the swelling only in the lower limbs. The dorsum of hands showed the skin peeling, and there was no swelling there now. The child took the breast well, but had thrush in the mouth.

November 10. — Temperature 97°. Further improvement. Right leg and thigh continued cyanotic and swollen, also about the nates, and especially on the right side. The upper part of the body was assuming a healthy pink colour. The whole skin was covered with dry desquamation. Repeat Apis.

November 14.—Urine tested by boiling and nitric acid, and contained no albumen.

#### DISCUSSION ON SCLEREMA NEONATORUM

November 21.—Temperature 98°, and skin much more healthy in colour and mottled; no blue colour now left. Right leg and labia still swollen, but very little solid œdema could be felt. The left leg had now quite recovered, and the tissues were now soft and flabby.

December 2.—Temperature 98°. Greatly improved, although right leg and thigh were still larger than the left, and its movements restricted. Any flexion or movement appeared to cause pain; it was kept immobile, while the left leg was freely moved. There were still hard patches in the tissues, giving the sensation of a “blind boil,” especially in the right labium, which continued enlarged and hard.

December 15.—Doing very well. Right leg natural colour, soft and warm. Moves it well. Appears to be well. Repeat Apis in 12th dilution every night.

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Dr. MADDEN thanked Dr. Roberson Day for the interesting paper he had read, and for opening their eyes to a new enemy that they might have to contend with. Dr. Madden had never met with or read of sclerema neonatorum before. Might he ask, under what conditions was the patient mentioned in the paper, born? Also whether in the investigation as to the cause, the thyroid gland had been examined at the *post mortem*? There appeared in many ways a suggestive likeness to myxœdema, and it would be interesting to know if there were any changes in the thyroid gland. It was also rather strange how extremely well apis had suited Dr. Day's case, because as far as his (the speaker's) knowledge went, the œdema that the apis produced was never of a sclerotic nature. Still, Dr. Day had done so well that they must not quarrel with him on that score.

Dr. EPPS added his thanks. He must confess that he had not seen a case of sclerema neonatorum, but from what he had read, it occurred to him that thyroidin might be worth trial.

Dr. WATKINS said that many years ago he delivered a primipara of a still-born full-grown child suffering from this disease. At the time he did not recognise it; and it was only after turning up the literature on the subject that he discovered what was the matter. Until then he thought that it was a case of rigor mortis. The woman had met with an accident a few days before she was confined; and he conjectured that the child had died then, and that the stiffness and the peculiar condition of the skin, which did not pit on pressure, was due to rigor mortis. With regard to the

pathology of the disease, he thought that the most likely theory that had been put forward was that it was due to the solidification of the fat, which depended on the peculiar composition of the infantile fat, which rendered it more easy to be solidified, and also to the low temperature. But against this it had been advanced that there had been cases of sclerema in which there had been a rise of temperature. But he did not think it had been proved that the condition did not begin with a low temperature. It was not at all likely that any subsequent rise of temperature would be sufficient to relieve the fat.

Dr. STONHAM remarked that the interesting point was with regard to causation. From the descriptions which Dr. Day had given, it seemed to be that solid oedema represented the condition more than anything else. They very often got conditions of solid oedema in long-continued oedema in different parts of the body, and which at last became solid and would no longer pit on pressure. The condition of the skin in the cases mentioned seemed to be very much the condition that obtained then.

Dr. ALEXANDER made a suggestion as to the treatment. Dr. Watkins had pointed out that the pathology of the disease might be a solidification of fat. Another theory was that it was from an error of the vascular distribution or the vascular supply of the skin. If those two theories were correct, it was just possible, he thought, that baryta carbonica might be of use. They knew that in certain vascular conditions it was a remedy of considerable value; and it was likewise recognised by some that it had a remarkable effect upon lipomata, in fact, he believed some of those tumours had been completely removed by the aid of the drug in high dilutions. It occurred to him that on that account it might be well to give it a trial in such cases as Dr. Day had described.

Dr. ROBERSON DAY, in replying, thanked his audience for the kind reception they had accorded his paper. No doubt there were many such cases as Dr. Watkins had mentioned to be found if one were only on the look out for them. He had been asked as to the conditions of the birth of the patient whose case he had recorded. The mother was an exceedingly careful and observant woman, the wife of a coachman in the neighbourhood of Montague Square, and the other children in the family were quite healthy. The labour was normal at full term. The surroundings, such as are usually found in the better class of stables. The thyroid gland was not examined, as no symptoms pointed to its being abnormal. In this disease the autopsies showed no abnormality in this organ. Nor

did the thymus show signs of disease. The obvious pathological changes took place in the skin, where there was a great proliferation of fibrous tissue and connective tissue corpuscles. More information was needed, and it was to be hoped this would be forthcoming from Italy, where seventy per annum die from this cause. The treatment by thyroïdin was certainly a valuable hint from Dr. Epps, and had the apis failed he (the speaker) should have been very glad, if he had the good fortune to meet another case, to try it. Dr. Alexander dwelt upon the case from its pathological aspect, the solidification of the fat. As he had pointed out, the solidification was owing to the peculiar constitution of the fat of the infant, the olein being less abundant than in the adult. Hence, any reduction in temperature caused solidification to take place. Strange to say, when he was treating his case, he heard through one of the members of the Staff of the North-Eastern Hospital for Children that a similar case had just been admitted there, so he at once made efforts to see the child. He arrived one hour after the child died, but not too late to see the body. The most thorough description had been given by Dr. Ballantyne, and the skin had been subjected to microscopic examination. There had been a large proliferation of the fibrous elements of the tissues in the subjacent tissues beneath the subcutaneous tissues and in the intermuscular septa. That seemed to be the chief abnormality—large proliferation of connective fibrous tissues and connective tissue corpuscles. He trusted that when any gentleman had the good fortune to see another case of the kind, he would bring it to the notice of the Society.

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## A CASE FOR DIAGNOSIS.<sup>1</sup>

BY J. R. P. LAMBERT, M.D., C.M.EDIN.,

*Assistant Physician to the London Homœopathic Hospital.*

ON Saturday, August 16, 1902, I received an urgent telegram addressed to Mr. Knox Shaw, who was then out of town, asking him to see a patient next morning at the Euston Hotel at 9 a.m. On my arrival there at the appointed time,

<sup>1</sup> Presented to the Section of General Medicine and Pathology, January 13, 1905.

I found that the patient, with her mother and sister, had arrived there a few minutes earlier, having travelled by the night train from Holyhead.

The patient, a tall, well-built girl of 19, gave the following history: She had been quite well till three days previously, when she experienced some epigastric pain, which she thought to be ordinary indigestion. She tried to ignore the pain, and went to a garden fête in the afternoon, but the pain was so severe that she had to resort to brandy once or twice. Next day she was seen by a local doctor at Beaumaris (allopath), who gave her some pills, which acted well. The day following (third day), the pain having shifted to the right iliac region, a consultation was held, and a diagnosis of threatening appendicitis arrived at. The temperature on this day was 102° F. Thereupon the father, a staunch homœopath, decided to send her to London to be under Mr. Knox Shaw. This meant a train journey from Beaumaris to Holyhead to catch the night mail to London.

The journey was well borne till about twenty miles from London, when she experienced very severe abdominal pain, described as almost intolerable. Some brandy was administered, after which she vomited. When I saw her at 9 a.m. she was in a collapsed state, in a cold sweat, with her face drawn, and still suffering abdominal pain. The temperature was normal, and pulse 120 to 130.

On examination I found the abdomen very tender, dull almost all over, and the muscles on the right side as hard as boards. She was ordered camphor every half hour, and hot bottles were applied, and, fearing perforation, I wired for Mr. Knox Shaw. At 11.30 she was much easier, temperature 102·2°, pulse 132, and the skin no longer clammy; she was put on the routine belladonna and merc. cor. 3, o. h. alt. At 4 p.m. Mr. Shaw saw the patient with me, and quite agreed in the diagnosis of appendicitis. The temperature was now 100·6°, pulse 125, and the skin clammy.

At 9 p.m. we saw her again, and found her much easier with temperature 101·2°, pulse 126, and the skin drier.

Next morning, August 18, 9.30 a.m., she had not much abdominal pain, but complained of a sharp pain catching

her breath round the right side of the chest. During the previous evening and night the bowels had acted several times. The urine was scanty and high coloured. Examination revealed a patch of friction just below the right breast, and weak breath sounds over the right lung in front. The abdomen was more tympanitic almost all over, and much less tender. Temperature  $101^{\circ}$ , pulse 126. Bryonia was now substituted for the belladonna.

9.30 p.m. note reads : Is easier, pain still on deep breathing, temperature  $102.2^{\circ}$ , pulse 134. Abdomen much less tender, bears palpation all over well, but there is slight tenderness in the right iliac region. Heart systolic beat in pulmonary region. Has had diarrhoea all day, twelve times ; better since milk changed. Bowels acted directly after taking milk, which caused pain. Stools watery. Has had epistaxis. During the afternoon at 5.30 her face was flushed and she seemed a little delirious—thought she was in a cab, &c.

The following day the abdominal tenderness had disappeared, and some crepitation was noted on the right side below the fourth rib in front, but no friction. Percussion was dull below the breast. The area of weak breath sounds extended well beyond the area of dulness. The temperature was  $101.2^{\circ}$ , pulse 124, respiration 18. Later in the day she again experienced some abdominal pain on the right side, with flatulent rumbling. On August 20 she was better. The bowels were quieter, and she had two formed stools. Friction was again heard on the right side, otherwise there was no change. She was now moved from the noisy ground floor room of the Euston Hotel to a flat in Hans Mansions.

On the 21st she was found to have had a restless night, having slept much the previous afternoon, and she complained of pain below the right costal margin, extending downwards. The temperature was  $102.2^{\circ}$ , pulse 114. On examination, no tenderness was found in the abdomen. Right lung was dull all over the axillary region and base, with weak breath sounds. A systolic bruit at the base of the heart was noted. Bryonia continued. The pain improved during the day.

Next day an additional note as to the pulmonary condition was made: Breath sounds weak over part of right lung, quite inaudible below the fourth rib, percussion dull. Weak breath sounds in this region had been noticed from the second day she came under observation.

She now complained of a pressure on the right side, and preferred to lie on the left. Next day (23rd) patient complained of pain in the hypogastrium and frequent desire to pass urine. Examination revealed more rigidity and tenderness over the right iliac region, reaching the middle line. In the chest crepitations were heard on the right side below the fourth rib, where the breath sounds were so persistently weak, and there was again a suspicion of friction.

The patient having been very restless again during the night after 1 a.m., the bryonia was changed to arsenicum 30, and a compress of ferr. phos. 1x applied to the right iliac region. That evening the temperature was 103.4°, and next day the abdomen was more tumid and tympanitic, and an ill-defined mass could be felt in the right iliac and lumbar region, which, however, was not very tender on pressure. During the afternoon the bowels were troublesome, there being frequent desire, relieved by passage of stool or flatus.

Next day (25th) the abdomen was found less tender and resistant, and the tongue was noted to be very red at the tip and brown at the base. Rhus was now given and the compress continued. That evening I was sent for hurriedly, and found her suffering from diarrhoea, which had supervened during the evening, after taking food, calves' feet jelly or chicken broth being possible exciting causes. It was painless, not very watery, and accompanied by much flatus. China  $\phi$  was prescribed, which was followed by complete cessation of the diarrhoea, but she had no sleep and was very thirsty through the night.

The following morning (28th) a globular swelling was found in the hypogastrium, and the tenderness in the right iliac region was noted to have disappeared. Bryonia given alternately with china  $\phi$  every two hours.

To eliminate the probability of the tumour being the bladder, the catheter was passed on two occasions by the nurse, but very little urine was drawn off.



Next day the swelling was described as more right-sided, but extending above the middle line, and as being tender to touch. The patient was now constantly passing mucus per anum. Continued bryonia, pyrogen 30, n. et m. added. The evening temperature rose again to  $103.6^{\circ}$  that day, and next morning I noted that the swelling reached nearly as far to the left of the middle line and half way to the umbilicus, its longest diameter being transverse. It was not now very tender and easily palpated. The bowels had acted slightly, and high-coloured urine was being passed freely.

On the 29th (fourth day of tumour) a note was made: "Tumour dull to three inches above pubes, and can be felt still higher," and there was now also more tenderness over the appendicular region. She was still passing much mucus, and now taking merc. cor.

Next day, having had a much better night, there was a general improvement, and the swelling was found to be only half the size it was the previous day, and by the afternoon, when she was seen in consultation by Dr. Lauriston Shaw, it was barely palpable, much to my disgust, and only an indefinite resistance deep in could be made out. During all these days the lung condition had remained much the same, and it was this that puzzled Dr. Shaw most, there being still the weak breath sounds, slight dulness and a few crepitations. The temperature was still high, the pulse varying from 110 to 115. She was now taking bryonia and hepar. Next day no tumour whatever could be felt, and the abdomen was much less distended.

From this time onward the abdomen caused no more trouble, and the interest of the case centred in the right thoracic region.

On September 1 I noted: Dulness at right base, no crepitations, ægophony at base. Breath sounds very weak over a larger area than the dulness.

On the 4th there was found to be absence of vocal resonance and weak breath sounds, but no absolute dulness, below the right breast, while the base was still quite dull. There was also tenderness on the right side below the costal margin.



Two days later Dr. L. Shaw saw the patient again, and we explored the right base with a large hypodermic needle, but found no fluid. He then diagnosed acute tuberculosis. The temperature was still high, up to  $103.8^{\circ}$ ; pulse varied between 100 and 112, respiration 18 to 20.

A week later, Mr. Knox Shaw having returned to town, he and Dr. L. Shaw saw the patient with me. The only change that had been noted in the week being that ægophony had disappeared; there was a small area in the axillary region where vocal resonance was absent. The only conclusion we arrived at was that exploratory operation was not called for.

The next day I went away (September 13), and left Dr. Grantham Hill in charge; and I may here mention a peculiar coincidence in the history of the case. The patient's father repeatedly told us that the case exactly resembled his own many years ago. He had a severe obscure illness, and was treated by Dr. Quin and others, who finally diagnosed acute phthisis. He then called in Dr. Aerzt, who diagnosed hepatic abscess, and while under his care he began to expectorate pus, and continued doing so for six months, and was finally cured. During my absence, on September 16 Mr. Shaw and Dr. Grantham Hill found a little pleural fluid at the right base. During my absence Dr. Byres Moir had also returned to town, and commenced watching the case with Dr. Hill.

On my return I saw the patient with Dr. Moir on October 3rd, and found that they had come to the conclusion that the patient was suffering from acute tuberculosis, and, as she was steadily losing ground, it had been decided to send her to Holyhead for open-air treatment at home. My note that day reads: Temperature still keeps up at night, lower in the morning. Is getting up daily, and taking ordinary food well. Right lung dull at the base, and weak breath sounds with some crepitations. Anteriorly also some crepitations and weak breath sounds, but no dulness (*i.e.*, below the third rib or so). Is taking ars. iod. 3x t.d., and tuberculinum every four days.

A few days later, October 7, she accordingly went to

Holyhead, and Dr. Hill accompanied to see her settled in, and open-air arrangements properly carried out.

On the 12th she began expectorating pus (till this time there had been practically no expectoration or cough); it commenced with a gush and then small quantities. This caused a general amelioration for two days, and on October 14 Dr. Hill returned to town, leaving the two nurses in charge. Later in the day she had a coughing fit, and brought up more pus, which at first was so very foul one could not stay in the room. That evening the temperature rose to  $104.8^{\circ}$ , and she felt chilly, but had no rigor. On the 15th about half a pint of pus was expectorated; the evening temperature was  $104.4^{\circ}$ , falling to normal in the morning.

Next day, October 16, Dr. Byres Moir, Mr. Knox Shaw and myself, proceeded to Holyhead prepared to operate. On arrival, we decided against interference on the ground that the pus was discharging freely, its site obscure, and the patient improving. The physical signs noted were dulness at angle of scapula, below and behind which was a small area of tubular breathing with pectoriloquy. We put her on pyrogen 30 and hep. 6 every two hours alternately.

Dr. Moir and Mr. Shaw returned the same night, and I remained in charge for four days. She was better the next morning, had had a good night, and made a good breakfast. Pulse 120, temperature normal. During the afternoon expectoration of pus became more copious and offensive, and was freely discharged till evening, suggesting the rupture of a fresh abscess cavity. On the 18th there was not much expectoration. The right base was dull to the angle of the scapula, below which there was a large area of tubular breathing with pectoriloquy, also a small patch less marked towards the axilla.

Anteriorly the level of dulness rose sharply in the anterior axillary line, parallel with the margin of the breast. Silica 6 given in place of hepar. The same evening I noted "cavernous breathing reaches the spine of the scapula, the cavity evidently rapidly enlarging." During the night expectoration became more profuse. Next day, 19th, I discovered tubular breathing with faint pectoriloquy

over the liver, below the 7th rib in the anterior axillary line, where, on percussion, a resonant note was heard. This was more marked by the evening of the same day. Late in the afternoon she brought up more offensive pus, and later on, pus and frothy mucus. Temperature  $102^{\circ}$ , pulse 144, respirations 44.

That night I returned to town, and Dr. Grantham Hill once more took charge, the patient being still in a critical condition. We also had oxygen sent down, which he found invaluable on more than one emergency.

On the 24th, after incessant coughing, lasting one and a half hours, with a rapid increase in the amount of pus she became very exhausted. The pulse reached 152, was very irregular, the temperature was  $104^{\circ}$ , and she turned a bad colour. Oxygen now proved of great service. From this point the temperature dropped to  $97.4^{\circ}$  next morning, the pulse steadily fell to 88 the following evening, and in the night, at 4 a.m. it fell further to 64, and the respiration became very shallow. This was accompanied by a general cold sweat with cold extremities, and the case looked hopeless. But the oxygen, which she had been getting fairly freely already, was increased; at 4.30 the respirations suddenly became stronger, and in five minutes the crisis was over. It was noted next day that a sudden rise in barometric pressure had occurred at just about the same time. She made a good breakfast next day and wanted to get up, and was in excellent spirits. She had no bad relapse after this, and the temperature never rose more than a few points over  $101^{\circ}$ . At Dr. Moir's suggestion, Stannum 6 now became the principal remedy.

Dr. Hill wrote on the 28th that the cavity seemed to be invading the middle lobe in front.

On November 5 he reported pus "still coming up freely, generally greenish now." The patient was now conscious, on coughing, of feeling hollow, and on deep breathing could feel air entering a hollow space. A few days later she was sufficiently well for Dr. Hill to return to town also, and, in spite of her many doctors, she made an uninterrupted recovery.

We did not see her again till October 14, 1903, when she came to London, and Dr. Moir, Mr. Shaw and myself, saw her together. She looked the picture of health and was feeling perfectly well. The physical condition on this occasion was interesting. There was no sign of thoracic deformity; both sides moved well, but the right less freely.

Over the right base resonance was impaired to the angle of the scapula, the breath sounds were weak and vocal resonance deficient. In front the breath sounds were normal. When recumbent there was dulness high up into the axilla and weak breath sounds over the dull area. In the nipple line the lower margin of hepatic dulness only reaches the 7th rib, below which the colon note is heard.

Chest expansion below nipple 31 to 33½ ins.; weight 10 st.

I will leave the case for your discussion before giving my own conclusions.

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Dr. GOLDSBROUGH remarked that it might not look very well to be wise after the event, but, as Dr. Lambert had put the history of the case before them, at this stage it did not appear to present much difficulty in diagnosis. He (Dr. Goldsbrough) regarded it as appendicitis which was pyæmic from the beginning. It reminded him very much of two cases he had had, which were somewhat similar, though not so severe. One was a case of appendicitis in which an abscess formed. It was before the days in which any abdominal surgery was done in the hospital, or else the case would not have been allowed to go on so long with medicines. But it so happened that the treatment proved successful. The symptoms were those of acute appendicitis to begin with, with fluctuating temperature following and after that expectoration of pus from the lung. He regarded the case as one where pus travelled from the abdominal region up behind the peritoneum. The other case was one he brought before the Society a good many years ago — a case which really was diagnosed as entero-peritonitis, but which nowadays they might say would be appendicular in origin, where several abscesses formed in the abdomen itself. That was not like Dr. Lambert's case except pathologically, and it suggested that pus did not primarily find its way into the abdominal cavity, *i.e.*, intra-peritoneally,

but was inclined to remain sub-peritoneal, and to follow the line of least resistance of connective tissue. A third case of his was one of hepatic abscess, which discharged in the right iliac region, so that pus travelled down from the liver, he took it, in the same manner. Dr. Goldsbrough's experience with these cases suggested that Dr. Lambert's was similar, although very much more severe. When the pus got thoroughly away from the chest, everything went well and the patient recovered.

Dr. MADDEN thanked Dr. Lambert for bringing before them this colossal case, or cases, one might almost say, for the poor patient seemed to have had appendicitis, peritonitis, pleuropneumonia, pulmonary abscess, and what not. He would like to ask whether the pus was examined for tubercle bacilli only, or for actinomycosis also. It reminded him in many ways of a case he had which was undoubtedly of tubercular origin. It was that of a girl who suffered from tubercular meningitis, in the course of which she developed acute peritonitis, and a swelling exactly similar to that in Dr. Lambert's case which arose from the pelvis. It appeared to be like a solid swelling of a mass of glands, and went down rather rapidly as the patient improved. She also had pleuropneumonic symptoms. This occurrence was another interesting point. Not only did pleuro-pneumonic symptoms ensue in the acute peritonitis which arose from the rupture of an ulcer, but in other cases also. He (Dr. Madden) had had a case which began apparently with peritonitis and which proved to be pleuro-pneumonia, with constant relapses of acute fever. Every day he was expecting to see some evidence of pus, which was never found. Eventually, after two or three months, the case cleared up. This was the same case the stomach of which was on the table last month as having a doubly ruptured gastric ulcer, and he was not at all sure now that the first attack did not start with a gastric ulcer, the inflammation extending through the diaphragm and setting up pleurisy in the thoracic cavity immediately adjacent. It appeared to him, although it was not certain, that Dr. Lambert's case was probably tubercular. It was, he believed, quite possible to have tubercular appendicitis. It was certainly possible to have all the other symptoms which had been described, and it only lacked the confirmatory evidence of the bacilli. He should certainly like to ask what was an objection to the tubercular theory.

Dr. GRANVILLE HEY said it might be of interest to some members to hear a little comparative pathology. It was not an uncommon thing in horses to get signs of acute inflamma.

tion in one part of the body, and within twenty-four hours to find them entirely transferred to another part. He had seen it repeatedly. A horse might one day show all the signs and symptoms of laminitis, *i.e.*, inflammation in the feet, scarcely being able to stand, and it would be treated for that; the next morning it would be found that the laminitis had gone, and there was either a well-marked pneumonia or enteritis. He thought similar metastasis might take place in the case of a human being. Referring to his South African experience, Dr. Hey said it was no uncommon thing to get a pleurisy following typhoid, and in more than one instance as soon as one pleurisy was better it developed on the opposite side. He had been wondering whether this case might not have been of typhoid origin. Many of the symptoms were compatible with that idea. He was going to ask if typhoid bacilli were found in the sputum; because in some cases where pus had been got from the chest after typhoid, the bacilli had been found in almost a pure culture, with scarcely any other organisms present in the pus. There was no reason as far as he could see why there should not have been pneumonia associated with the definite abscess; and the crisis that was referred to was more like a pneumonic crisis than anything he had heard of—the really serious, critical condition of the patient one night and the extreme comfort and well-being and satisfactory condition by the next morning.

Dr. NEATBY said the case described by Dr. Lambert must have been an extremely interesting and perplexing one to watch from the beginning to its termination. Pus might travel upwards behind the diaphragm or through the diaphragm, or along the course of the inferior cava, and might involve the liver, the lung, or the pleural cavity. A young lady had been out in connection with a school treat and entertained the children. She had a good deal of fatigue and exposure, and the next day was seized with extreme abdominal pain, mostly epigastric, and in the right hypochondrium. She was very ill indeed for two or three days, and then the symptoms gradually lessened. She did not fully recover, and was treated in the country for a hysterical condition. She was supposed to be almost malingering, and was made to get up and travel and get about. This lasted four or five weeks. When she came to London after a somewhat prolonged journey she was found at once to be extremely ill; and how the condition could have been overlooked it was very difficult to say. There were a high temperature, a flushed face, and profuse perspirations; and evidence of inflammatory infiltration in the whole of the right

loin. When Dr. Moir saw her with him (the speaker) very soon after her arrival, they found almost complete dulness in the right chest up to, he thought, the angle of the scapula or a little higher, and absence of breath sounds and so on. There was no difficulty in diagnosing this feature of the case. The signs were very well marked. The whole case turned out quite satisfactorily after the complete evacuation of the most offensive pus he had ever experienced, and also evacuation of a lot of pus from the loin by separate incision. There was one difficulty, however, in diagnosis, the same which existed in Dr. Lambert's case, namely, as to the origin of the inflammation in the first instance. Dr. Moir suggested it was probably a case of rupture of the stomach, the viscus having been isolated, but no fatal symptoms being produced at the time. He thought the surmise of Dr. Goldsbrough as to Dr. Lambert's case was probably a more or less correct one, that there had been some appendix inflammation in this case, and that either inflammation or actual pus had travelled upwards and had affected the lung. Personally, he should be inclined to say it was an abscess in the lung, because many of the symptoms were very much like coincident pneumonia.

Dr. LAMBERT, in reply, said after due consideration of the various possibilities, he had come to the conclusion the diagnosis of the case was appendicitis followed by hepatic abscess discharging through the lung. He was aware that this diagnosis did not explain all the anomalies, but certain facts forced him to this conclusion, which was the opinion he was inclined to throughout. The two factors to which he attached the greatest importance were the physical signs of a cavity over the hepatic region without evidence of downward displacement of the liver and the marked upward and backward displacement of that organ found twelve months later. Moreover, a primary thoracic lesion would not account for the collapse and state of the abdomen on the railway journey to London. The next most likely diagnosis was perforating gastric ulcer with localised peritonitis, subphrenic abscess becoming subsequently more general, but the early symptoms were too mild for that, and the physical signs quite different from the only case of that kind he had seen. He did not quite agree with Dr. Goldsbrough's view as to pus travelling up behind the peritoneum. Some German professor had made a statement that in appendicitis a very rapid transference of inflammation through the lymphatics might occur through the diaphragm setting up pleurisy within quite a few days of the onset of appendicitis. The pleurisy in this case was



not of a purulent character. In the fluid that was drawn off by Mr. Knox Shaw from the pleura on the second operation, September 16, a full month after the onset, there was no pus. There was no tubular breathing until the abscess opened. One of the most peculiar symptoms was the absence of vocal resonance in the mammary region. The condition which to his mind would best account for the lung condition would have been a diaphragmatic pleurisy forming empyema, but that would not account for the abdominal condition, *i.e.*, the sign of cavity below the diaphragm. With regard to Dr. Madden's question, he thought the pus was examined twice, but only with a view to ascertaining whether there were tubercle bacilli. There was no sputum before the pus appeared, and no cough to speak of. Then Dr. Madden mentioned the combination of pleurisy and peritonitis. That was a well-recognised condition; and there may be pericarditis too. He had seen two or three cases of that kind. The two best marked cases he had seen were both fatal. He did not think his present case had originated with a gastric ulcer. In that alternative the abscess would have been subphrenic and the early symptoms much more severe. He thought it must have been in the liver. It was altogether below the pleural margin, and there was no displacement of the liver with it. If the pus had been between the liver and the diaphragm the cavity would have closed as soon as the pus escaped and given no physical signs of a cavity communicating with the lung.

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## SYPHILIS OF THE BRAIN.<sup>1</sup>

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MR. PRESIDENT AND GENTLEMEN,—My object, within the scope and limit of a short paper, is to discuss the clinical and main features of syphilis of the brain. This disorder is more or less familiar to us, yet its signs are occasionally ignored, and more often misinterpreted; and this is as much due to the fact pointed out by Gowers, that “there are no symptoms

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and no combinations of symptoms, produced by syphilis, that are not also produced by other causes," also to the cursory way in which the subject has been handled in the text books. One can think of few diseases where an incorrect diagnosis does more harm.

Symptoms of involvement of the nervous system occasionally—bad symptoms rarely—occur while the secondary rash is on the skin. A patient had violent occipital pain, mostly nocturnal, from about the fifth month after infection for three or four months. There was a tender spot on the occipital bone when examined. Specific treatment cured within three weeks. Dr. J. Hutchinson has recorded a number of paraplegias within one year and even within six months of infection. Lancereaux, in his classical treatise, gives a number of striking cases belonging to this period. One of these shows some of the typical features of a specific encephalopathy. A man, aged 39, after a sore throat had a history of intense headache, insomnia, and giddiness. Then followed a left hemiplegia. Six weeks after the head symptoms began he was examined. An obvious secondary rash—papular and pustular—was found on various parts, an exostosis on the left clavicle, and a gumma (?) on the extensor side of both forearms. There was an incomplete left hemiplegia, with embarrassed speech, weak memory, a heavy expression, and clouded intelligence. Under mercury and iodide all these symptoms began to subside. In a few days the right arm became paralysed, and he dragged the right leg. The dose of iodide was increased. A fortnight later he left the hospital temporarily cured.

It is thought that gummata never occur in the brain with a secondary roseola. Still, diffuse gummatous inflammation has been met with even thus early. And were it not the rule for an infected subject to apply for treatment, either for the primary sore, or for the early pains, swellings, and eruption, it is quite possible that early gummatous formations would not be so uncommon. An illustration of early cerebral lesion was recently given by Dr. T. R. Bradshaw, *Lancet*, July 16th, 1904. A man, aged 25, took syphilis, and was had treatment for seven months. No secondary

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MR. PRESIDENT AND GENTLEMEN,—My object, within the scope and limit of a short paper, is to discuss the clinical and main features of syphilis of the brain. This disorder is more or less familiar to us, yet its signs are occasionally ignored, and more often misinterpreted; and this is as much due to the fact pointed out by Gowers, that “there are no symptoms

<sup>1</sup> Presented to the Liverpool Branch, Jan. 12th, 1905.

and no combinations of symptoms, produced by syphilis, that are not also produced by other causes," also to the cursory way in which the subject has been handled in the text books. One can think of few diseases where an incorrect diagnosis does more harm.

Symptoms of involvement of the nervous system occasionally—bad symptoms rarely—occur while the secondary rash is on the skin. A patient had violent occipital pain, mostly nocturnal, from about the fifth month after infection for three or four months. There was a tender spot on the occipital bone when examined. Specific treatment cured within three weeks. Dr. J. Hutchinson has recorded a number of paraplegias within one year and even within six months of infection. Lancereaux, in his classical treatise, gives a number of striking cases belonging to this period. One of these shows some of the typical features of a specific encephalopathy. A man, aged 39, after a sore throat had a history of intense headache, insomnia, and giddiness. Then followed a left hemiplegia. Six weeks after the head symptoms began he was examined. An obvious secondary rash—papular and pustular—was found on various parts, an exostosis on the left clavicle, and a gumma (?) on the extensor side of both forearms. There was an incomplete left hemiplegia, with embarrassed speech, weak memory, a heavy expression, and clouded intelligence. Under mercury and iodide all these symptoms began to subside. In a few days the right arm became paralysed, and he dragged the right leg. The dose of iodide was increased. A fortnight later he left the hospital temporarily cured.

It is thought that gummata never occur in the brain with a secondary roseola. Still, diffuse gummatous inflammation has been met with even thus early. And were it not the rule for an infected subject to apply for treatment, either for the primary sore, or for the early pains, swellings, and eruption, it is quite possible that early gummatous formations would not be so uncommon. An illustration of early cerebral lesion was recently given by Dr. T. R. Bradshaw, *Lancet*, July 16th, 1904. A man, aged 25, took syphilis, and was said to have had treatment for seven months. No secondary



symptoms were noticed. A year after infection, having had severe occipital headache for three weeks, he was suddenly seized with right hemiplegia. For about twenty-four hours the paralysed side was convulsed. There was aphasia, but no loss of consciousness. Three months later he could walk with the aid of a stick. Here we have an early syphilitic arteritis, with thrombosis of the left middle cerebral artery, in spite of a lengthened course of treatment.

It is after the first, and up to about the tenth year after infection that the cerebro-spinal system is most open to attack. Statistics make the ratio of this form of syphilis to the sum of tertiary cases between twelve and twenty per cent. I am now considering only the clinically separable form which is a direct syphilitic involvement, characterised by the same morbid formations that syphilis produces in other parts of the body, and amenable to anti-syphilitic treatment.

It is the civilised brain which syphilis attacks—a brain active and therefore much used, and therefore subject to fatigue. Whatever congests the brain, whether intemperance or constant intellectual labour, makes it more liable to become diseased. The morbid changes are very simple. They involve directly the meninges, the connective tissue, and the blood vessels. The nerve-fibres and cells are thus subject to injury by pressure atrophy, by a scanty supply of arterial blood, by necrosis due to arterial thrombosis, and by mechanical destruction due to hæmorrhages from arteries and capillaries. In the meninges and connective tissues the essential lesion is an invasion of their substance by small round cells, which multiply with varying rapidity according to their situation, and cause a thickening by inflammation of these tissues, so that they may adhere to one another, to the nerve substance, or to the skull wall. These adhesions are characteristic. By a more rapid multiplication of these cells in certain areas those vascular aggregations of new tissue are formed which by growth and further changes become “gummata.” Gummata in the brain have a peculiarity of distribution yet to be explained. Among their favourite sites, according to Dowse, are the upper frontal convolu-



tions. Virchow mentions the anterior part of the base, especially about the *sella turcica* and the third frontal gyrus, also the basilar fossa. Of seventeen cases of gumma of the brain thirteen were cortical, three in the pons, one in "the region of basal ganglia and lateral ventricles." (Starr.) They are rare growing from cranial nerves, but H. M. Thomas, from his careful and detailed record of an autopsy, concludes that they are likely to be found growing from an artery where this crosses a nerve.

One at least of the arterial changes—the obliterative endarteritis of Heubner—is familiar to us in books on pathology. The other important type of lesion begins in the adventitia, which is invaded, congested, and partly replaced, by the small round-celled growth, a process which extends to the outer coats of the vessel. Compensatory to this partial destruction of the muscular coat occurs a thickening of the intima by connective tissue by which the vessel is strengthened, at the cost of its elasticity and calibre. Gummata may arise from the adventitia. By either of these processes the lumen is obstructed until obliteration may occur by a final thrombosis at the narrowest part. This accounts for the gradual loss of power followed by sudden total loss of power so often observed clinically.

Starr's opinion, from a large clinical experience, is that gumma is the commonest form of tumour in the adult brain—*i.e.*, commoner than sarcoma and glioma. Mott has recently said that the syphilitic is by far the commonest form of organic brain disease in adult life. In children, gumma is very uncommon in nerve tissue, so rare in fact that it is only just worth consideration. Sachs, moreover, tells us that, even in syphilitic children, he has never seen a meningitis *per se* which was clearly syphilitic. Ocular palsies and headaches, or evidence pointing to a localised brain tumour, may accompany those exceptional cases of specific spinal paralysis which are met with in children. Barlow found the cortex hardened in syphilitic infants. The explanation of this general rarity is probably that death occurs either *in utero* or during the first year of life in a case of sufficient severity to affect the nervous centres or any important organ.

Out of a total of 2,072 boys suffering from chronic nervous disease, as idiocy, imbecility, epilepsy, and various paralyses, Bournville found a syphilitic heredity in only 20. For 482 girls similarly affected the percentage was even lower, .2 per cent. This estimate is doubtless gained by the inclusion of epilepsy and paralysis, and would be much higher for idiocy and imbecility alone.

The symptoms of cerebral syphilis are often unmistakable because of their variety and irregular distribution. There is no other cerebral morbid anatomy which has the features so often met with in these cases, where extensive areas of meningitis may co-exist with multiple growths of varying size and position, and with patches of ill-nourished brain substance. It follows that, as Dr. Norman Moore is fond of insisting, the physical signs are rarely unilateral. They are, moreover, subject to curious and rapid alterations. This is no doubt due in part to the varying conditions of the blood supply to areas fed by diseased vessels, some of which are closing up while others at the same time are undergoing a partial and temporary clearance of morbid tissue from their walls. The following abbreviated case is chosen to illustrate the great variety of symptoms and signs, the tendency to improvement and relapse, and the surprising result of treatment in apparently hopeless conditions. A man, aged 46, had suffered from headache for three years, with partial amnesia, and occasional convulsive seizures. Then, in the course of an indefinite illness, occurred gradual loss of power in right arm, then in right leg with partial aphasia. Shortly after he similarly lost power on the left side. At this time much vertigo, with weak memory for words (word blindness) and partial motor aphasia. Memory, speech, and power of movement then slowly returned together. When seen, at this stage, there was no sign of past syphilis except a nodular condition of left testis. In a month he greatly improved as an asylum in-patient. Ten days later headache returned, memory deteriorated, he walked as though afraid of falling, said he saw double and that objects appeared blue, and had aural hallucinations. These aggravations mainly nocturnal. By day was lethargic, must be roused to

take food. Incontinence of urine and fæces. Six days later, at 6 p.m., a maniacal attack, followed by partial coma, with dilated pupils. There was right facial paralysis, paralysis of left third nerve, and of right arm, with paraplegia. Temperature in right axilla  $102.3^{\circ}$ , in left  $101.6^{\circ}$ . Respirations 40. Two days later the face regained power, and temperature, pulse and respiration, normal. A day after was conscious when roused, and tried to answer questions. Five days later, quite conscious and rational. The paralysis soon disappeared except for weakness of left side of body, and he walked well. Speech better than before seizure, no headache. He was observed for some months further, seemingly nearly well. (Dowse.)

The mental aberrations share in this inconstancy. There is a general confusion of mind. Delusions, if present early, are incongruous and quickly change. Dr. J. MacBride draws attention to the negative character of early mental symptoms. There is loss of "mental power" and of self-control, weak memory, loss of interest in surroundings, and liability to anger and crying. "Blind-spells" and transient aphasia are important signs of the early stage. Charcot said that irregular temporary aphasia is characteristic of arterial disease of the brain. There are some curious cases showing the cause of some temporary aphasias, monoplegias and paraplegias. An ill-nourished brain area easily tires, and ceases to work till rested. So, after speaking a little, or walking a short distance, these motor functions—not to speak of non-motor functions—are temporarily suspended.

The syphilitic insane are, as a rule, either melancholic or demented. Both states are partly curable, but the tendency is towards relapse. The general tendency of nerve syphilis when untreated is towards a rather rapid termination in death. The usual fate of such cases is to be treated intermittently. They keep developing fresh lesions when taking no medicine, and each lesion produces a further disorganisation, slight or severe. Though many improve with surprising rapidity under iodide and mercury, they are only temporarily immunised. In other cases too much damage has been done, and specific remedies have little or no effect. In yet

a third class treatment is at first successful, but finally fails to arrest fresh developments. Dr. Buzzard speaks of a condition observable in syphilitics who have had numerous relapses. These people "are usually not above the middle period of life, and go about as chronic invalids, with one or more of their limbs paralysed, and exhibiting, in addition, more or less marked impairment of mental powers. This may consist chiefly in defect of memory, or they may have delusions, sometimes of an exaggerative character, and are often extremely indolent and slovenly and stupid. These conditions may alternate with periods of great improvement, in which there seems ground to hope for an eventual recovery, but they never, even at their best, return to a sound mental condition. Their friends, to whom they are a constant source of anxiety, always describe them as much changed in character, and eventually they sink into a state of confirmed dementia, or succumb rapidly in a state of mania."

Dowse's description of a patient with extensive arteritis is worth giving almost *verbatim*. There is much headache; there may be ptosis of one side, passing off and succeeded by ptosis of the other side; temporary strabismus and diplopia, or visual sensations; tinnitus with deafness; vomiting, constipation, and persistently furred tongue. Speech may be hesitating, even aphasic, with facial spasm; gradual paralyses, quickly passing off, are met with. The patient is lethargic, yet cannot sleep. He will be "restless, all his doings and movements without definite purpose." He has to be reminded to take food, is apt to let things fall from his tremulous hands, and finally may "neglect and appear to be regardless of the calls of nature." This is the kind of state ushering in syphilitic apoplexy. The coma to which these patients are liable is usually a deep stupor, but it is possible to rouse by painful stimulus to a state of hardly more than automatic consciousness. This coma may last from a few hours to two or three weeks. Finally consciousness returns, paralyses clear up together with the mind, and the patient may even go back to his business. But the second attack is either fatal, occasionally preceded by a series of convulsions, or its paralyses are long lasting or permanent.

Gowers analyses fifty cases of syphilis of the brain (Lettsomian Lectures, 1892). Of these fifty, four had symptoms beginning from the sixteenth to the twentieth year after infection. He instances a man who contracted syphilis at the age of 18, and at 37 was struck with right hemiplegia, subacute paraplegia supervening at 38. In these fifty, the commonest manifestation was hemiplegia, slight and transient in some, in others so severe as to leave, after a slow return of power, permanent weakness of arm and hand, with late rigidity. Headache usually preceded the seizure, but seldom by more than six or seven weeks. It was usually severe and general, or worse on the side of lesion. The onset of paralysis was sudden in a few, but in most slow and deliberate.

The headache of syphilis is well known, but probably in many cases wrongly diagnosed. It is usually agonising, and its extreme severity may even cause a wish for death. In one case because of the pain the patient "thought he would lose consciousness." An acute observer says "when asked whether the head aches the patient's face becomes woebegone, the brows are slightly knit, the corners of the mouth depressed, the head drops towards the chest, and the tips of the fingers are placed upon each temple. Added to this the sorrowful voice and upturned eyes leave no doubts as to the reality of the suffering." The scalp should be felt for tender spots and possible areas of raised surface-temperature. Pain is, as we have seen and noticed clinically, by no means always confined to a small area. It may be hemicranial, involve face and jaws, or any of the anatomical regions. In tertiary cases it is often diurnal. Dowse says that pressure increases it, and that the violent pain accompanying dural disease may cause hyperalgia of neck and upper extremities. We are indebted to the same observer for a description of a form of headache met with in cases of extensive cortical arteritis. It is "not essentially nocturnal or paroxysmal," but comes on "with great severity for twenty-four or forty-eight hours, perhaps not oftener than once in three or four weeks, yet rarely in the intervals leaving a perfect sense of freedom." Excitement may, however, bring it on at any

time. The pain is dull, heavy, aching, having no central point but diffused over the forehead; the eyelids can scarcely be raised, the conjunctivæ—one or both—may be congested; the patient “has a hang-dog look.”

The convulsions of tertiary syphilis are usually seen in conjunction with less equivocal symptoms. Any form of *petit mal* may occur, as well as incomplete or complete convulsive attacks, from a twitching or spasm of a group of muscles without loss of consciousness up to the typical *grand mal*. If such manifestations be found alone, they have either preceded or will soon be followed by symptoms more indicative of their origin. Thus, after treatment, the cerebral disease may clear up, with the exception of some scar-tissue involving the cortex on the site of a former gumma or patch of meningitis, whereby convulsions are kept up in spite of medicine. Here are two instances of the reverse condition:—

A man, between ages of 30 to 32, had three or four epileptic fits. When seen, aged 32, he was thin and pale; complained of great weakness, confusion of mind, sense of weight on forehead and vertex, flatulent dyspepsia and loss of flesh. There was sense of tingling in both hands, and paræsthesia of right side of face. He suffered much from insomnia, had sudden feeling of breathlessness several times a day; the right leg was moved clumsily, and both it and the right arm felt numb. Iodide relieved him very speedily. Infection six years before the first fit (Buzzard).

A man, aged 30, developed numbness and slight local muscular twitchings on left side of face. Two months later had dimness of sight and right diplopia. Two months after this the molars in right upper jaw became so loose that he pulled them out with his fingers. When examined, pupils myotic and inactive to light and accommodation. Vision and fundus of each eye normal. Under mercury, iodide, and strychnine, he greatly improved. Four months later he presented himself with advanced primary optic atrophy of both eyes and complete paralysis of the third nerve. There were no signs of tabes, but treatment was now ineffectual (*Lancet*, April 12, 1902).

Dowse notices in the major fits the frequency of a state

of sub-consciousness, the reflexes being rarely abolished to strong impressions; for example, the iris reacts before strong light. The face is rather pale than cyanosed; profuse salivation often occurs. Sometimes an attack lasts for many hours with intervals of delirium. The universal tonic spasm is rarely seen. The patient is often left with a localised paresis, which passes away in course of time. Buzzard remarks the frequency of severe preceding headache, and the Jacksonian type of fit. Jackson noted that a double optic neuritis, with convulsions beginning in either hand, especially in the first two fingers, and spreading up the arm, formed a clinical syphilitic type.

Syphilitic convulsions take their place as one of a congeries of symptoms, and accompany a well-marked derangement of body and mind. Quite another picture is afforded by the parasymphilitic epilepsy, separated of late years by A. Fournier in a masterly essay. Beginning in the middle-aged, the subjects of acquired syphilis long past, but who otherwise enjoy good health, it is ushered in by a few isolated attacks of *grand mal*, or by *petit mal* soon succeeded by *grand mal*. After a year or two of this, it continues as *petit mal* only, which lasts for an indefinite period, and is only influenced by bromide, which, in large doses, reduces the frequency of the seizures.

The term "parasymphilitic" implies a compromise rendered necessary by the *a posteriori* method of scientific inquiry. It also serves to reconcile the extremists on both sides. Yet, undoubtedly, it shows an illogical position, as at present understood. Is it not probable that all those diseases which are separate entities in all respects have but one cause, though now they may acknowledge several? Regarding the discussion on general paralysis, the suggestion of Dr. Mott is most reasonable, that this disease has one cause—syphilis, the exciting agent being any habit which in the non-symphilitic would tend to neurasthenia, or a state of chronic nervous fatigue. The following percentages, showing the estimated syphilitic history in general paralysis from the time when inquiry was first directed to the subject, speak for themselves:—



Magnan, 4; Siemerling (for women), 11; Kraepelin, 34; Westphal (for women), 40; Erb, 52; Mendel, 75; Mott, 70-80; Savage, 80; Alexander, 88 (1902); Fournier, 51-92 (for twenty-seven sets of cases); Spillmann and Dengler, 93.

Krafft-Ebing stated that of his 2,000 observed cases, 90 per cent. were in military officers, and none in Roman Catholic priests. Other statements in this direction might be quoted, as that of Salaris, who said that in Sardinia for the years 1891-1897 only one case of general paralysis occurred in a priest, who was certainly syphilitic. The case for juvenile general paralysis is corroborative of what has been said. It is to be hoped that the history of the other parasymphilitic affections will be subjected to as close an investigation.

Reference has now been made to most of the important clinical signs of syphilis of the brain. In the younger section of its victims rapid diagnosis is often fairly easy. And this is fortunate for the busy practitioner, whose task it is in a minimum of time to discharge both his conscience and his debts. There are prominent clinical appearances, due to asymmetry of the paralyses. Sometimes the co-existence of evidence of widely separate disease in the cerebro-spinal axis makes the case clear. In other instances the peculiarity in the succession of symptoms is pathognomonic. Thus, in a recorded case there was in January paralysis of right sixth nerve, in May weakness of left fourth, in November paralysis of left third and fourth, incomplete right hemiplegia with exaggeration of deep reflexes—a crescendo of varying manifestations. Some present themselves, as Buzzard noted, with a “muddy pallor” of countenance, a dazed expression, and a peculiar thickness of utterance. Cerebral syphilitics are usually pale and thin. They have also an appearance of exhaustion; and this is an important element in the clinical picture, for though brought about by much headache and insomnia, it is often noticeable in late syphilitics who are little troubled with either. A good many, especially in elderly life, bear the stamp of alcoholism; and this of course may mislead. The writer lately saw a woman, aged 58, who had all the look of an old broken-down



inebriate; and the characters observed at first—shuffling gait, slight paresis of the right side, with mumbling speech—were attributable to central lesions by atheroma. Both pupils, however, were found to be fixed before strong artificial light. This well-known sign, be it remembered, is occasionally found, as MM. Babinski and Charpentier have demonstrated, as an initial and sole symptom. The subject is a candidate for cerebro-spinal syphilis, or tabes, or general paralysis.

The diagnostic importance of anti-syphilitic drugs is understood by three facts. One is that their effect upon syphilitic neoplasms is a certainty; another is the ready diagnosis of most of those late cases in which they are inoperative; the third is their ineffectiveness upon non-gummatous tumours of the brain. True, iodide has a favourable influence in certain cases of glioma, but this is temporary and partial.

In the case of epilepsy, the exclusiveness of this drug is complete. It has, according to experiment, no power over non-syphilitic epilepsies, but, as we know, the syphilitic convulsion ordinarily needs nothing else, though, when the attacks are very numerous, bromide will usefully reinforce the other salt.

With ourselves, accustomed as we are to minute “dynamic” dosage, it is, perhaps, of use to remember that a small and tentative dose of iodide will often fail, where a massive dose, increased according to need, will at last work wonders. It is astonishing how much of this salt the system can accommodate, even in an acute and menacing disease like lobar pneumonia, with nothing but benefit. Horsley gives anti-syphilitic treatment the test of six weeks; Starr would continue it for double that period.

The progress of syphilitic cases, of course, is often by no means peculiar to themselves. We may be confronted with a hemiplegia, for example, for which such symptoms as headache, convulsions, optic neuritis, vomiting, and so on, whether present or not, do not make for a differential diagnosis. Here two considerations will help—the nature of the succession of preceding symptoms and of the “prodromata” themselves,

and the mode of onset of the weakness. Gowers, in his able review of the subject (*op. cit.*), is careful to remind us that the onset of a syphilitic paralysis is either subacute (within one week) or sub-chronic (within three weeks). In this way we can exclude both embolism and the more gradual loss of power accompanying certain non-syphilitic tumours which happen to affect the motor region. The syphilitic hemiplegia, in fact, may be said to lie in time between the acute and chronic positions.

The paralytic development may take some hours, several days, and even a fortnight or more. In those uncommon cases (as that quoted above) where the onset is comparatively sudden—from a few minutes to half an hour—consciousness is seldom altogether lost. And this is the case also where the loss of power gradually increases and spreads and is suddenly completed.

The signs for the detection of cerebral syphilis are the same during the degenerative period of life as heretofore. Cases in the old demand greater nicety of diagnosis, still the indications given continue to hold good.

Every supposed case of general paralysis should have the benefit of a course of anti-syphilitic treatment. This maxim from experience is gained through the occasional simulation of general paralysis by a true tertiary syphilitic affection, the “general pseudo-paralysis” so styled by Fournier. The literature contains a certain number of such cases, whose existence is worth remembering.

Dr. Mott says that cerebral syphilis is more likely in those who have nearly or quite escaped other tertiary affections. It is possible also that late syphilis of the nervous system is commoner in those who have had slight symptoms throughout. The evil may thus be two-fold; for the symptoms may escape notice from their insignificance, or be so carelessly reckoned by the patient that he neglects to take medicine. A denial of syphilis may be made by those who have some final sign of it, simply because memory is faulty, or the illness was slight and many years ago, or when it occurred was misinterpreted. Of the larger class of deliberate mis-statements, it is enough to say people will conceal unpleasant

truths even from themselves; and under those circumstances are not likely to acknowledge them to others. It is therefore scarcely necessary to recommend that the physical should be preferred to the oral record, a preference which has led to discoveries in other fields than medicine; and that the wisest course is to strip the patient and make a detailed examination of every accessible part.

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## A PATHOGENETIC AND CLINICAL STUDY OF DELPHINIUM STAPHISAGRIA.<sup>1</sup>

BY JOHN MURRAY MOORE, M.D., C.M.EDIN., M.R.C.S.ENG.,  
F.R.G.S.

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WHEN honoured by the invitation of the Secretary of the Section of Materia Medica, Dr. Stonham, to contribute a paper on some subject connected with homœopathic materia medica, I selected Staphisagria for several reasons.

Firstly, I have never failed—I speak advisedly—to obtain relief to my own sufferings from that wearing, wearying and worrying pain of all varieties called *toothache* (*odontalgia* sounds far less formidable); secondly, I have very seldom failed to relieve or cure the large number of sufferers I treat at the great tobacco factory where I am medical officer; thirdly, because this remedy has greater possibilities of usefulness than have hitherto been exploited; and, fourthly, because an attempt to collect as much clinical information as is or seems trustworthy appeared to me thus far unaccomplished, and yet desirable.

As a proof that staphisagria has been overlooked in our standard literature, I may mention the two facts: first, that in the first twenty-seven volumes of the *British Journal of Homœopathy* this medicine is only mentioned four times (two out of these being of no use to the seeker after knowledge), and, second, the remarkable omission by our late

<sup>1</sup> Presented to the Section of Materia Medica and Therapeutics, February 2, 1905.

much-lamented colleague, Dr. Richard Hughes, of staphisagria in his sections on toothache and on neuralgia in his last book, "The Principles and Practice of Homœopathy."

In fact, during the last thirty years the only articles and papers devoted to the subject of my present contribution have been those by Drs. Bayes ("Applied Homœopathy"), A. C. Clifton (*M.H.R.*, xxi., 469), and E. T. Blake (*M.H.R.*, xxxv., 361); and yet the development of this whilom parasiticide into a valuable internal remedy against at least three diseases is a grand proof of the practical utility of our great founder's system of proving drugs.

The plant which supplies our staphisagria is the palmated larkspur, which grows in the south of Europe, and belongs to the tribe *Helleboreæ*, of the natural order *Ranunculaceæ*. We homœopaths owe much to the remedies of this precious order, as a glance at the chart before you will show. Here we have side by side the leading symptoms of aconite, pulsatilla, cimicifuga, ranunculus bulbosus and sceleratus, helleborus, hydrastis, clematis and staphisagria. This is one of the methods of education in symptomatology used in the Homœopathic Colleges in the United States:—the chart well repays study, though but sketchy in its outlines.

The medicinal energy of this plant resides in the ripe seeds. These are dried for the chemist; they are blackish-brown in colour, deeply pitted on the outside, and their inside is whitish, soft and oily; the taste is nauseous, bitter, and acrid. From the fancied resemblance of the seeds to raisins, the Greeks named this plant "staphis agria" (*σταφίς ἄγρια*), that is, "wild raisin."

#### ALLOPATHIC PHARMACEUTICS.

The crushed seeds yield an essential oil called "oleum staphisagriæ," which is made into an ointment with lard and used as a parasiticide in scabies and phtheiriasis. An older form of ointment, composed of the macerated seeds, benzoated lard, beeswax, &c., is said to be somewhat irritating to the skin.

Balmanno Squire's analysis has revealed the existence

of two alkaloids named delphinina, delphinia, or delphinine ( $C_{24}H_{35}NO_2$ ) and staphisagrine, which probably give to the seeds their peculiar properties.

Delphinina, of which I hand round a specimen, is an amorphous, resinous alkaloid of yellowish colour. It is a poison to the amphibia and lower mammalia, like aconitine causing slowing down of the pulse and respiration, paralysis of the spinal cord, and death by asphyxia.

In the *Lancet* and *London Medical Recorder* for 1887 it is recommended for relieving neuralgia in doses of one sixtieth of a grain.

Staphisagrine—probably the cutaneous irritant, perhaps the parasiticide constituent of the seeds—is analogous to veratrine and curarine, paralysing the motor nerves in frogs, and killing mammals without convulsion by paralysing the respiration.

#### HOMŒOPATHIC PHARMACEUTICS OF STAPHISAGRIA.

Our mother tincture, prepared by maceration and percolation with S.V.R., is transparent, or faintly straw-coloured, and forms a cloudy precipitate when dropped into water, which is quickly re-dissolved.

As the seeds are very oily—here are some *au naturel* and some powdered—and as I find the tincture of staph.  $\phi$  varies in colour as supplied by different chemists, I suggest that a stronger and more uniform tincture could be made by using ether as a menstruum, as in the case of lycopodium  $\phi$ , the ethereal preparation of lycop. being, I find, more energetic than the triturations.

The English name “stavesacre,” is an imitation of a modern foreign rendering of the Greek appellation, so this plant can claim a respectable antiquity. The interest to us of its classical allusions lies in the probability that it was the experiment made by Dr. Schulze of chewing the seeds to relieve toothache, as recommended by Dioscorides, and the agonising exacerbation that followed of all his pains that first drew Hahnemann’s attention to this drug.

The great Master foresaw much value in staphisagria as

a homœopathic remedy. He took it up with his usual energy, and assisted by his daughters and twelve faithful disciples, produced a body of provings the full significance of which has not yet been recognised by his successors.

The "Cyclopædia of Drug Pathogenesis" has omitted this Hahnemannian legacy, and gives under the word "staphisagria" only a few experiments on animals with its alkaloid, delphinine, summarised by von Boek, Lauder Brunton, and C. D. F. Phillips, and some nineteen symptoms derived from varying doses taken by S. Schroff, Turnbull, Falk, and Röhrig, and by a patient of Albers. We, however, as homœopaths learn nothing from these records that we did not already possess in aconitine—derived from another of the *Ranunculaceæ*.

The reason for the omission of the 721 symptoms of staphisagria from the Cyclopædia is in the preface. The authors of the "Cyclopædia of Drug Pathogenesis," it seems, were instructed not to *reprint*, but to *refer to* the pathogeneses of Hahnemann because—"we have no means," they state, "of verifying, correcting, illuminating them, or of reforming their order, the day-books of the provers not being extant."

The earnest student of homœopathy must go to Allen's huge work if he wishes to know all the Hahnemannian medicines. And here, even, in staphisagria, there are translations in Allen that do not agree with Teste's rendering of the original; as for example, in symptom 43 in "Head," where Teste's translation is "Vertigo when sitting, as if things were turning round, decreasing by walking in a circle (Cubitz)," whereas Allen's is "whirling vertigo, especially while sitting, relieved<sup>1</sup> by walking about."

Teste classifies staphisagria along with causticum, cocculus, coffea, corallium, nux vomica, and arsenicum,—causticum being the *type* of the group No. VII. He selects a large number of symptoms out of the provings and dogmatically asserts that staphisagria is curative in all those conditions; but gives no definite case. Now I propose to bring before you the leading symptoms of Hahnemann's provings, arranged in the order of the Schema, illustrating *each*

<sup>1</sup> Better translated "diminished" (Dr. J. G. Blackley).

section by *recorded clinical cases*; in this following the lucid arrangement of kali bichromicum by Dr. W. T. Ord, printed in 1899—after which pattern I think all our *principal* medicines should be arranged for students.

If this attempt at the compilation of what is thus far known of a venerable but little-used remedy should be deemed worthy of being printed, I shall be repaid for the prolonged labour I have bestowed on it.

The careful search I have made through the British and American homœopathic literature of the last thirty-five years has not been as fruitful in clinical illustrations of staphisagria as I had hoped, but, still, some useful facts and practical suggestions have been collected, some of them, perhaps, new to my colleagues.

Hahnemann's enthusiastic praise of this remedy has hitherto not been repeated by any of his followers, but staphisagria, though not a polychrest, will, I am convinced, prove of value in more diseases than the three it is already accredited to, viz., toothache, spermatorrhœa and recurrent styes.

In his *Materia Medica Pura*, Hahnemann records 283 symptoms produced on himself and his relations, and 438 reported by his followers—Cubitz, Franz, Gross, Gutmann, Hartmann, Haynel, Herrmann, Hornburg, Kummer, Langhammer, Stapf, and Teuthorn. If anyone wishes (as I do) to know something of the personality of these provers, Dr. T. Linsley Bradford, in the pages of the *Homœopathic Recorder* for 1895-6, has published what is known—not much, certainly—of these men.

We will begin with the first section, marking the “starred” and “full-faced type” symptoms.

### I.—*Mind and Emotions.*

\*Disinclination for mental work. Thoughts disappear whenever he attempts to think or speaks of any subject, and, if interrupted, he forgets, and cannot collect his thoughts.

\*Weakness of memory. A few minutes after reading anything he can recollect it only dimly, &c.



Fretful and peevish all day. \*Very peevish in the morning; wishes to throw from him everything which he takes in his hand. Alternation of mood, at first joyous, then anxious, at last quiet and contented.

The mental symptoms have determined Dr. C. Hering's choice of this remedy in several instances. He considers *extreme impressionability* of mind, and the effects of indignation or wounded pride, to be characteristic of staphisagria. Dr. Majumdar, of Calcutta, strongly recommends staph. 30 in cases of loss or weakness of memory afflicting students who have been weakened by sexual excesses or by masturbation. He has cured several such cases. The effects on the brain of a sensitive person of either sex of anger and indignation at unfounded charges have been successfully removed by staphisagria, as the following case shows.

*Case 1.*—G. M., aged 60, had been for fifteen years subject to epileptic fits every month or every two months, originated by the mental shock of being falsely accused of infidelity to his wife. Allopathic treatment had completely failed to cure, so he came to Dr. Cigliano, of Naples. Guided by the cause of the mental disturbance, although so remote in time, Dr. Cigliano chose staph. 30 giving it every morning for a period not specified, and cured him so completely that at the time of reporting the case five years had elapsed without any return of the fits.

Dr. Adolph Lippe regards this (starred) symptom, \**“Very peevish in the morning, wants to throw away anything he takes up,”* as unique, and therefore a key-note for staphisagria.

## II.—*Head Symptoms.*

Confusion-vertigo symptoms six times. Whirling vertigo especially when sitting, relieved by walking about (Teste, walking in a circle). \*Headache, as if the brain were compressed, with roaring in the ears, &c. Heaviness of the head, relieved by resting it on the hand. Three provers felt pressive, stupefying headaches; four experienced compressive or pressing asunder pains in the occiput. Stapf records a striking sensation: *“Pain in the head, as if everything would*



come out at the forehead on stooping." Compare this with symptom 32 of *coffea cruda* and symptom 92 of *laurocerasus*.

The most remarkable subjective sensation, which may possibly prove to be unique, and therefore a key-note of *staphisagria*, is this of Hahnemann's, symptom 67: "\*On shaking the head there is a sensation in a small spot in the middle of the forehead, as if there were something heavy, like a ball of lead, in the brain, which would not loosen." I am not aware of any other symptom anywhere exactly like this. Dr. T. S. Hoyne writes: "We find it useful when there is a sensation as of a round ball in the forehead, &c., &c.," but gives no cases.

*Case 2.*—Dr. A. C. Clifton (*M.H.R.*, August, 1877) narrates a case cured by *staph.* 30, after trying in vain the third and sixth dilutions, of a literary man who had taken mercury for liver disease, and was in a debilitated condition. He suffered from a dull, stupefying pain in the head, producing a muddled feeling in the brain, or as if a hard substance were pressing on the skull. All mental work was a trouble, ideas were slow in coming, and he could not find the right word to express an idea.

Here our now venerable colleague may be congratulated on having so clearly diagnosed, described, and adopted the *similimum*, *staphisagria*, to all these characteristic sensations.

Next, as to the scalp, we find itching, or biting, or burning needle stitches in the scalp in three provers; two had falling of the hair, itching, scurfy, dry, but sometimes moist eruptions, the itching being aggravated by scratching or by rubbing. The most peculiar symptom was No. 111, \* biting and itching on the upper part of the occiput, with sore pain recurring in the same place about the same time in the evening.

*Case 3.*—A cure of *porrigo capitis* by *staph.* 12 is reported by Dr. Ussher in the *Homœopathic World* for December, 1893. The patient was an apparently healthy flaxen-haired boy, but the patches of eruption were offensive in odour, "smelled like mice-dirt." "For months I gave him *staph.* 12 *ter die*, and whenever I stopped it the head got worse, but by perseverance it removed every patch over scalp and behind the left ear."

I cannot find this condition of *foetor* in any of the skin symptoms of *staphisagria*, but Dr. Ussher selected it for this case upon a "tip" from Dr. W. V. Drury. "Dry eruption of scalp, *hepar*; moist, *rhus.*; stinking, *staph.*"

III.—*Eyes and Eyelids.*

There are thirty-seven separate symptoms, of which ten are starred, and one, "itching of the margins of the lids," in full-faced type. I can only quote a few. First, we have the general symptom of "nervous exhaustion." The eyes lie excessively deep, with blue raised rings around them, as after great excesses, lasting four days. Second, the eyes soon begin to ache when reading; the eyes are dim and hot; phosphenes at night, a halo round the candle, scotomata when reading or looking into the open air. Third, dryness of the eyes in the morning, dryness in the evening, morning agglutination of the inner canthi, biting, smarting of the inner canthi, \* pain as if a hard substance were lying beneath the left upper lid, &c., &c.

There seems to be a consensus among homœopaths that staphisagria is one of the best remedies for chronic blepharitis with morning agglutination, and for hordeolum, *i.e.*, meibomian cyst.

Drs. Baehr, D. A. Strickler, C. A. Bacon, Allen, Norton, and Vilas have printed cases showing the power of staphisagria both to cure and to prevent the recurrence of styes. It shares this honour with pulsatilla.

*Case 4.*—Dr. C. H. Vilas, oculist, cured in three weeks by staph. 3x a Miss D., a brunette, who had suffered for many months from a succession of styes, more than twenty in number.

*Case 5.*—Dr. Koch (Hoyne, p. 510) cleared away by staph. 1 a steatoma, the size of a lentil, growing upon the inside of the lower eyelid of a lady (Mrs. B.) aged 32, who had been operated on for the removal of similar tumours twice before she consulted Dr. Koch—six years, and two years, previously.

Dr. W. Bayes (whom I whimsically remember as a wonderful counterpart in face of Professor Max Müller), found staph. 12 curative in weakness of the optic nerve, and in smarting pain in the eyelids coming on in the evening and preventing the patient from using the eyes by artificial light.

The experience of Schott, of St. Louis, United States, confirmed by C. A. Bacon (*Hom. Recorder*, November, 1896),

goes to show that staphisagria "relieves almost entirely the severe bursting pain in the eyeballs, temple, and side of face, worse from the evening to the morning, and upon using the eyes by artificial light—of syphilitic iritis."

Dr. Bojanus, of Moscow, recommends staphisagria in "fistula lacrymalis."

The foolish habit of reading in bed by gas or candle-light, in which many young people indulge, is, in my experience, the fruitful source of styas and of chronic redness of the eyelids. I shall now, with my enlarged knowledge of this medicine, use staphisagria in these cases

#### IV.—*The Ear and Nose Symptoms*

are not remarkable. The chief are: a tensive stitch in the left ear, ringing in one or other ear on moving the head, which disappears during rest (160). Sensation of coldness streaming into the right meatus auditorium like a cool breath.

Nine provers had coryza, three having "violent coryza," and two provers had soreness or sore pain in the septum and nares. I have not seen any nasal cures by staphisagria recorded.

#### V.—*The Face, Mouth, Teeth and Gums.*

Symptom 182 given by Stapf is striking—"He looks as hollow-eyed and haggard, and as sick and pinched in the face as after a night's watching, or as after a disagreeable mental shock." We have also "throbbing and pressive pain in the whole of the face, extending from the teeth into the eye, swelling of the cheek over the lower jaw, pressive tearing in the left cheek bone, then cutting, drawing, swelling, and hardness of sub-mental glands, painful on swallowing or when touched, or when rubbed by the neck band.

Of facial neuralgia I have two cases here:—

*Case 6.*—An old lady who for years had suffered from excruciating neuralgia of both sides of face and forehead came to Dr. Bayes in a deplorable state. Mastication was impossible from the pain

it induced, and the patient had to live upon sops put into her mouth by her fingers; for the least contact with a spoon, fork, or anything metallic, always brought on a violent attack. The relief afforded by staph. 30 and 12 was remarkable, and made life bearable for her until she passed away. Sympt. 202 of staphisagria is "sensation of fine cutting in the lip, as if it were cracked"; and this poor lady's sensations were expressed as "fine cuts with a very sharp knife, beginning at the lips and extending to the eyes and above the orbits." Surely this is a "similius"; but Dr. Bayes does not give us his reason for choosing staphisagria in this peculiar case.

*Case 7.*—An attack of neuralgia of the inside of the right cheek, between the lower gum and the cheek, and also in the gum itself, but not in the teeth, intensified by blowing the nose, was cured in two days by staph. 6 (J. W. Carter).

*Case 8.*—Dr. Edmund Hughes, of Liverpool, son of Dr. Richard Hughes, has kindly sent me the following recent case of face-ache:—

Mary M., aged 23, shortly after an attack of influenza, began to suffer from facial neuralgia. Shooting pains started from the upper molars on both sides, and darted into the ears and orbits, especially on the right side. The pains came on at irregular hours of the day or of the night, and were relieved only by local warmth. It had lasted five weeks. After arsenicum 2 and magnes. phos. 2 had failed, staph.  $\phi$ , one drop every two hours was given. The second dose gave much relief, there was no pain next day, and the relief was permanent, although three molars and the stump of one bicuspid were found to be carious, and were not extracted for some time afterwards.

Dr. Bayes himself obtained striking relief in "tic-douloureux" from staphisagria.

We now come to that part of the human organism which the whole homœopathic world, lay as well as professional, *know*, by a century of experience, to be quickly, selectively, and beneficially affected by delphinium staphisagria. Nowhere in Allen's grand collection of provings is the principle of *similia similibus* better illustrated than in the "teeth, gum and mouth" symptoms of this good old remedy. Out of thirty-three well-defined pathogenetic symptoms no less

than fourteen are starred and italicised, showing that at least these fourteen have been clinically verified.

As "things seen are mightier than things heard," I have had printed in parallel columns the guiding symptoms of three prominent toothache remedies — my favourites — namely, plantago, rhododendron and staphisagria.

It is worth noting that seven provers suffered from artificially-induced toothache and caries, spongy or pale and retracted gums, &c.

With even the array of remedies for this distressing though every-day ailment presented by Lilienthal to the number of seventy, by the industrious Jahr to the extent of thirty-six, and by the repertory to the up-to-date "Cyclopædia of Drug Pathogenesis" to the liberal amount of fifty-two, with all these riches *it is not easy to cure or even relieve every case of toothache.*

My own field of observation of this disease, as sole medical officer to a large tobacco factory employing 2,000 workpeople, has been pretty extensive.

Out of 1,145 patients treated at the surgery (which is free to all employèes) during the past year 1904, I noted ninety-nine cases of toothache, eighteen of faceache, and twenty-five of conjoined toothache and faceache. Every single case of all these three diseases was relieved, and a large proportion cured. Staphisagria was used in ninety of the cases of toothache, plantago, kreasote, merc., sol. or puls. being employed in the remaining nine. Rhododendron was not available, as I do not stock it, and plantago was used only from the beginning of December.

I place these remedies in order of merit, thus: first, staphisagria; second, plantago major; third, rhododendron.

It will be useful to narrate a typical case of each.

*Case 9.*—Mary T., aged 18, tobacco worker, came to me January 19, suffering from severe toothache in the left upper molars for a month past. As she dreaded going to a dentist, she endured it until it became incessant for the last two nights and days. Only one molar was carious, but the pain, which was described in the very limited vernacular of these girls as "tearing

# SYNOPTICAL CHART OF THE DENTAL SYMPTOMS OF

PLANTAGO.

STAPHISAGRIA.

RHODODENDRON.

Teeth feel elongated in the morning, and then ache from 2.30 to 4 p.m. each day: the pain is sharp, stabbing,—Toothache on the left side, before and after breakfast, went off in the forenoon, returned after dinner. Teeth of left side feel elongated and sore: violent pains in the sound upper molars of left side, excessive boring digging pain with pressure

on that side. Soreness and elongation of the sound teeth: cold feeling in front teeth. Pain in a carious molar with swelling of cheek, which remained after the pain had ceased. Grinding of the teeth while asleep. Rapid decay.

The teeth soon become black-streaked. Caries is hastened. Tearing pain after eating and chewing; also after drinking anything cold: The hollow teeth are and if after eating the sugriest food remains in the cavities, there is violent pain, extending to the roots of the sound sore. Pain aggravated by motion in the open air; by drawing cold air into the mouth; at night; early in the morning; and during menstruation. The gum bleeds when pressed upon, and on cleaning the teeth. The gum becomes pale and white. Ulcer on the inner side of the gum.

Violent drawing pain in right lower the approach of thunderstorms, or of cloudy or windy weather: the pain in one prover (Helbig) commenced on the ear of same side. Toothache accompanied with ear-ache all night in left lower jaw and teeth. Pressure sometimes relieved, sometimes increased the pain; warmth of bed had no influence. Grumbling and tearing in molars, now in upper, now in lower jaw, sometimes right, sometimes left. Transient pain in single teeth in damp weather and before a storm. Saliva increased and has a sour taste.

<sup>1</sup> Mr. J. S. Hurdall writes: "My own severe toothache was relieved by holding cold water in the mouth, but it returned as soon as the water became warm; yet it was cured by Staph."

and pulling," *i.e.*, the "drawing" of our pathogenesis, spread to the sound teeth in its neighbourhood (this symptom staphisagria has in common with plantago), was worse after eating, by exposure to cold air, and by drinking any cold liquid, but is not affected by changes of weather; gums sore and inclined to bleed. I gave her minim doses of staph.  $\phi$  to be taken every two hours. On January 21 she came and stated that the pain ceased after the second dose. On January 26, having continued the staphisagria all the time, but only three times a day, she reported herself well, having no pain whatever. It is a help to plug a hollow tooth sometimes with a pledget of cotton wool soaked in the oil of staphisagria. It never creates irritation of the gum.

*Case 10*, from the N.A.J.H., September, 1893, is worth citing on account of its exact corroboration of the "caries and black streaked appearance of the teeth (symptom No. 208). A girl, 20 years old, had scarcely been free from toothache for two years. Her teeth were blackened, and decayed rapidly; they were sensitive to touch and painful; they also felt elongated. Staphisagria 3 every two hours gave immediate relief to the pain, and, continued for several weeks, actually arrested the decay. The toothache never returned. Her regular dentist remarked upon the much greater hardness and healthier condition of her teeth than before taking staphisagria.

#### *A Plantago Case.*

*Case 11* in my own surgery practice well illustrates the differential selection and prompt action of plantago major.

Alice P., clerk, aged 21, dark-haired, pallid, slightly anæmic, came to me crying with intense toothache on January 20. The pain was in the left upper molars, one of which had a carious spot, not visible without a mirror; they were white and sound externally. The pains were of a dragging, pulling character; they went off after breakfast, but returned after dinner, being worst from about 2.30 onward till tea-time; they are worse by hot water in the mouth and by going into a warm room from the open air. She had endured this pain for three weeks, but, as it kept her awake all the night of January 19, and the left cheek was now swollen, she sought my aid. Led by the conditions of aggravation, I gave her plantago  $\phi$ , two-drop doses of the tincture every two hours. Next day she returned quite cheerful, stating that the third dose had stopped the pain. Continued plantago, half the



dose, thrice a day. On the 25th she was still free from pain, and on the 31st, eleven days from beginning the medicine, she was dismissed cured.

### *A Rhododendron Case.*

*Case 12* is from the practice of Dr. Hirschel, of Prague, reported in the *British Journal of Homœopathy*, vol. xxvii., p. 149. The patient, Baron H., had for a long time suffered from violent faceache, the pain spreading over the right side of the face from the teeth and gums. The pains were drawing, tearing or jerking, equally intense by day and by night, aggravated by wind and changes of weather, relieved by warmth, and disappearing while eating and for some time afterwards. He suffered most in spring and autumn, which are the most changeable seasons for weather of the year. All his decayed teeth had been extracted in Vienna without any relief to his pains. Dr. Hirschel chose rhododendron from the symptom (168 in Allen) "violent drawing pain and disappearing by eating." After the *first dose* of two drops of rhodod. 1x the patient had his first tranquil night for several weeks, and by the third day all pain was gone.

*Case 13* is also a good illustration of the "change of weather or storm aggravation," absolutely characteristic of rhododendron.

Dr. Budd, of Los Angeles, California, had a patient, Mrs. ——— aged 44, a spare anæmic lady of highly nervous temperament, who had suffered for three years from faceache, when she wrote to him for medicine May 11, 1896, from her home in Kansas City. The pain is greatest in the right lower jaw, and is sometimes made easier by eating or chewing gum. Usually an attack is brought on by high winds, damp weather, or an approaching storm. This lady is particularly afraid of thunder. The pain is aggravated by movement and by hot applications. Rhodod. 15x was sent by post. Ten days afterwards Mrs. ——— wrote stating that each of the first four doses so aggravated the pain that she stopped taking the medicine, but next morning the pain had gone. She wrote some days later that "she was so free from pain that she forgot she had ever suffered." A slight twinge on June 7 was quickly stopped by rhodod. 1,000, and it never returned.

### *VI.—The Throat Symptoms*

are only nine in number and not distinctive. Scraping sensation on the fauces, &c., the sub-maxillary glands are



painful, as if swollen and bruised. The only starred symptom is No. 268. \**“Throat rough, as if painfully sore, when talking and swallowing.”*

Dr. J. H. Clarke, arranging for clinical purposes a synthesis of the ear and throat symptoms, derives a key-note for staphisagria (*H. W.* Jan. 1890), which he gives thus: “When the patient, in a case of enlarged tonsils, complains of stitches flying into the ear, especially the left ear, on swallowing (sympts. 165, 166), the remedy is staphisagria. The following case illustrates this:—

Case No. 14. Frank S., aged 23 on March 23, 1889, came to the hospital with the following symptoms, which he had had for a month, after a cold: Pain in throat and chest, worse in the morning, gets up thick stringy phlegm, tonsils rather large, the left sore to the touch; *slight stitch flies to the left ear on swallowing.*

He was cured by staphis. 30.

Dr. Clifton has seen benefit from staphis. 3 and upwards, given to young persons of either sex for chronically enlarged tonsils, when there also exists an unhealthy condition of mouth and gums, and a general herpetic discrasia.

#### VII.—*The Stomach, Appetite, Digestion, &c.*

Ravenous hunger, even after a hearty meal, thirstlessness, scraping heartburn, frequent hiccough, qualmishness (thrice repeated); water collects in the mouth with short isolated eructations, as from an emetic which would not act; nausea, even to vomiting every morning.

Dr. Teste adds a symptom which I do not find in Allen—“long-lasting vertigo, accompanied by continual nausea, as in sea-sickness,” and says in a foot-note: “From this symptom, which I experienced several times on myself, I inferred that staphisagria might perhaps be a good remedy for sea-sickness.” Teste tried to interest 100 of his patients in this remedy. He supplied each traveller with one dose of staph. 6, instructing them to take it at the first sensation of discomfort, viz., vertigo and nausea before actual vomiting began. Out of twenty who gave him any report at all,

seven who were bad sailors, and who had on previous trips taken cocculus and arsenicum unsuccessfully, were prevented from being sick; eight were strikingly relieved, and five were unaffected. He notes also that staphisagria always helped nervous persons, not over fat, and disposed to sadness. Surely we may add this to our remedies for sea-sickness, the chief of which, in my experience, is the good old-fashioned nux. One of the symptoms I have quoted above indicates staphisagria as appropriate. Teste asserts it to be of all drugs the best remedy for this reflex trouble, and C. D. F. Phillips corroborates the recommendation by clinical experience.

This original and observant author (Teste) had a strong belief in staphisagria as an antidote to the effects of excessive use of tobacco. Other physicians have not endorsed this, but the case of Captain C., a military officer who had for years frightful attacks of gastritis, so bad that his case was diagnosed by three eminent medical men of France as cancer of the pylorus or duodenum—was quickly and for a long time cured by Teste's prescription of staph. 12; and it was afterwards found that his serious disease was entirely due to smoking. When he dropped this habit, for which his constitution was not fitted, he recovered completely without any medicine.

In his "Materia Medica," published in 1853, Teste (?) asserts that staphisagria will cure "old gastralgias caused either by coffee, or by the oriental custom of swallowing (does he mean inhaling?) the tobacco smoke.

My own four years' experience proves that nux vom. is *the* antidote to nicotinism, next after that arsenicum, ignatia, and pulsatilla, in order of efficacy.

A custom in our factory that some men have of alleviating toothache by placing a plug of chewing tobacco on the offending tooth has its inconveniences, for if the man swallows it, it produces promptly all the symptoms of sea-sickness.

#### VIII.—*Abdomen, Rectum, Anus, &c.*

The leading symptoms include colic, borborygmi, bruised pain in the abdominal walls, incarcerated flatus, which

when passed is hot, or offensive; constipation for several days, followed by thin slimy diarrhœa; \* a smarting sore pain in the rectum for a long time after a stool; \* itching in the anus while sitting; long delay of stool on account of lack of peristaltic action of the large intestine.

Dr. Oehme, in the *American Homœopath* of 1882, reports his experience that many cases of chronic constipation can be cured by 2-drop doses of staphisagria  $\phi$  tincture, taken twice daily.

Bell, in his excellent book on Diarrhœa, after giving a good summary of this section of provings, remarks: "Staphisagria is too often neglected. It is a valuable remedy for chronic diarrhœa, or even dysentery of weak, sickly children, resembling chamomilla and mercurius in many symptoms, but also showing marked and distinctive differences. A humid, foetid eruption is almost always present, and furnishes a strong additional indication."

*Case 15.*—Dr. Preston reports a case thus in *Hoyne's Clinical Therapeutics*, I., 512:—"A case of hæmorrhoids, with intense pain in the back and through the whole pelvis, and enlargement of the prostate gland, was cured with staph. 200, the pain ceasing after the first dose."

I can personally testify that staph. 3x cures itching of the anus, due to hæmorrhoids.

### IX.—Genito-Urinary Organs.

(a) Kidneys and bladder.—Pressure upon the bladder on awaking from sleep; \* a burning in the whole of the urethra with every micturition; frequent urging to urinate, with much discharge; \* urging to urinate; scarcely a spoonful was passed, mostly of a dark yellow-red colour, in a thin stream; at times dribbling of urine, always followed by a sensation as if the bladder were not yet empty, for some dribbling continued; on coughing, the urine involuntarily spurted from her; \* more frequent micturition of very scanty, dark-coloured urine for three days.

Nowhere in our *Materia Medica*, except in cantharis, have we a plainer picture of a drug-eneuresis. Accordingly,

Dr. Clifton used it for years in the enuresis of both sexes with success.

*Case 16.*—Dr. G. W. Homsher reports the following case:—Mrs. F., aged 23, had enuresis for six months after her first partus, which was instrumental. The urine had become so acrid as to excoriate all the adjacent parts, and cause severe burning pain, aggravated by motion. A stool only every two or three days was passed, with straining and pressure on the bladder. Staph. 18 and 30 produced no improvement, but staph. 3 cured her completely in nine weeks.

I shall notice Dr. E. T. Blake's treatment of this distressing complaint in females under the Surgical Section.

(b) Female genitals. — \*Painful sensitiveness of the pudenda; on sitting down it hurts; itching, biting, or spasmodic pain in the vagina; the menses, which had ceased for a year, reappeared, with cutting colic and violent rumbling, &c.

Dr. G. W. Homsher (*Med. Gleaner*, Dec., 1877) gives as special indications for the use of staphisagria in female bladder affections, "disturbances in nerve centres, neuralgic pains in the pelvic organs, restlessness at night, hysterical excitement, and when the patient is subject to dysmenorrhœa."

(c) Male genitals.—The primary action of staphisagria causes great sexual desire; in the secondary effect, or reaction of the organism (after five or six days), there follows indifference and total lack of sexual desire both in the sexual organs and in the emotions. This is Hahnemann's lucid summing up. But we may notice the frequency of the seminal emissions, with or without dreams, on three and on five nights in succession. Also this (starred) symptom 402. \*"Pressive pain in left testis while walking, as also after rubbing; still more violent when touched."

I believe that the value of staphisagria in the form of spermatorrhœa described by Lallemand, as pointed out by Hughes in his "*Pharmaco-dynamics*," is generally recognised. In this disease the chronic inflammatory irritation of the prostatic portion of the urethra extends into the ejaculatory canals and the seminal ducts.

Dr. Bonjean writes in *Hoyne* that staphisagria is the most efficacious remedy for masturbation, "particularly in cases of long standing, where there is hypochondria, with great taciturnity, constant uneasiness as to health, queer notions that expose the patient to the suspicion of being thought crazy; where there is great deficiency of animal heat, the eyes are deep sunken and lustreless, gnawing toothache with caries of the teeth, indigestion, constipation, continual loss of the prostatic fluid, &c.

I have myself done much good by staphisagria in cases not so advanced as Bonjean's foregoing type: that is, I have reduced the number of emissions to about the normal amount (which I assume to be once in three weeks), but never have I cured the vile habit which causes them, nor the erotic dreams which excite them. Phosphoric acid and *eryngium aquaticum* have given me greater and more uniform results than has staphisagria.

Dr. Clifton strongly recommends staphisagria in chronic inflammation and enlargement of the prostate gland in old men, and that distressing perineal pain which is excited by riding or driving in a carriage. "In one case, associated with hæmorrhoids and constipation, where nux, sulphur, æsculus, and others had failed to relieve, staphisagria 3 was of service."—*M.H.R.*, vol. xxi., p. 472.

In its influence on the male genital organs, staphysagria resembles *Clematis erecta*, also a member of the Ranunculaceæ.

#### X.—*The Respiratory Organs.*

The twelve cough symptoms which sum up the experiences of four provers—Hahnemann, Franz, Gross, and Kummer—are undoubtedly pharyngeal. A case of toothache accompanied by cough described as "sharp," or "violent," or "tickling," with usually tenacious, scanty, or difficult expectoration, would lead us to prescribe staphisagria in the full hope that it would clear away *all* these symptoms.

The chest symptoms abound in the expression "stitches," or sticking, "sharp stitches," &c., all in the muscular walls of the chest, whereby we are reminded of the natural

relationship to the ranunculi of our subject. If anyone will compare symptoms 436 to 453 of staphisagria with symptoms 175, 188 to 192, 204 to 206 of *Ranunculus bulbosus*, he will perceive a close relationship. It seems to me that in this section we have a practical keynote in symptom 449—"violent stitch in the right side of the chest while sitting, on bending the upper part of the body obliquely forward, and to the right side." I shall try staphisagria in my next case of pleurodynia on the right side.

#### XI.—*The Heart Symptoms*

are not distinctive. Palpitation after the afternoon nap, on slight motion, while walking, and when listening to music, were all that were elicited. Compare aconite, cactus, and iberis amara.

#### XII.—*Neck, Back, and Extremities*

may be taken together in one section. For staphisagria produces pains of a rheumatic, or gouty, or neuralgic character in all these regions of the body. We lack here, in these old-fashioned provings, the analysis and estimation by weight of the solids of the urine, as in some later provings. Therefore we prescribe staphisagria on a symptomatic, not a pathological basis, in such cases as I now mention.

Dr. E. T. Blake tells us that his father, Mr. J. D. Blake, of Taunton, first in this country used staphisagria with success in the sciatica of old men, whether gouty or rheumatic-gouty in its nature.

*Case No. 17.*—Dr. Clifton records a good cure of sciatica of the right leg in a lady who had previously suffered from intercostal neuralgia, followed by herpes zoster. The pain was worse early in the morning, on rising, or on sitting down, and was better by standing and by warmth. After failure of other remedies staphis. cured, and a slight relapse three months later was quickly removed by the same medicine.

*Case No. 18.*—Dr. E. T. Blake's case of myalgia of the left deltoid muscle, narrated in his paper on staphisagria, of

May 7th, 1891, is a good one. After six months of suffering, staph. 12 and 1 absolutely removed the pain in seven days. I refer you to the paper, printed in vol. xxxv. of the *M.H.R.*, p. 370, for particulars.

Dr. Bayes has cured neuralgia of the shoulder-joint and arms with staph. 6 or 12.

*Case No. 19.*—Dr. Hesse (*Allg. Hm. Z.*, No. 128) describes an interesting cure of writer's cramp, in a lady of 30 with staph. 6. Having treated her for eighteen months previously with very little success, one day he was told that she had suffered from scorbutus shortly before her cramps began, and that since then she had frequently had bleeding and ulceration of the gums. Thereupon he ordered staphis. 6 in frequent doses with permanent good results to both gums and hands. She has now been a year (1894) without any need to take medicine.

Those of my colleagues who know how wearisome real writer's cramp is to cure by medicine alone will appreciate this excellent result.

*Case No. 20.*—Dr. M. Preston's case of cure of chronic neuralgia of six years' duration affecting the right anterior crural nerve is worth mentioning, although its pathology is not very clear. Mrs. A., aged 30, never pregnant, had always suffered from irregular, late and painful menstruation. Ten days previous to the due period sharp pains on motion extending down the whole length of the right crural nerve used to torment her. This pain passed into a partial paralysis of the right leg until the catamenia fully appeared, when all these sensations passed off. There were night-sweats, general prostration, and amelioration of all the pains during rest at night. Staphisagria cured in three months.

### XIII.—*The Skin.*

The action of this drug on the cutaneous system is unmistakable and decided, but there is but one symptom (No. 646) which might be considered unique, and therefore a key-note. "Itching over the head and whole body, especially in the morning; a creeping, itching and crawling, as from the creeping of an insect which goes from place to place" (Hahnemann). Let us prove this in our practice.

Itching, papular eruptions on face, behind the ears, on



the neck, hands, abdomen, thighs, around the joints—all characterised by burning after scratching. Existing ulcers on the leg became worse, and painful with biting and burning. I cannot find any *moist* eruption produced purely and primarily by this drug, unless, indeed, "tetter" means a vesicular eruption.

*Case 21.*—Dr. F. Preston reports the cure of dry tinea capitis in a child of 10, which had lasted *eight years*, by staph. 30, effected in the short time of two months. The choice of the remedy was determined by the blepharitis which the child also had.—*Hahn. Monthly*, February, 1880.

*Case 22.*—Dr. M. Macfarlan, of the U.S., cured a papular itching eruption on the face and behind the ears, the skin of which was rough and dry, in a three-months-old infant, with staph. 200 in thirty days.

#### XIV.—Generalities, Fever, Sleep, &c.

The most notable symptoms are these : \* Weariness and weakness of the body in the morning. \* In the morning in bed she is very weary without sleepiness. *All the limbs are sore, as if bruised, and as if there were no strength in them for an hour* (full-faced type). \* Great weariness and sleepiness after eating; feels the need of lying down, &c. Sleep disturbed with vivid disagreeable dreams. Amorous dreams with emissions. Spasmodic jerking, though painless, of arms and legs frequently in the night for several nights. Violent yawning fits. Rigors without subsequent heat and without thirst. Rigor about 3 p.m. several days. Profuse night sweat. Sweat of the odour of bad eggs towards midnight.

Trinks quotes Hartmann (one of the provers) as recommending staphisagria in the first stage of typhus fever, when there is blackening and rapid destruction of the teeth.

The *Journal of Practical Medicine* (No. IX, 1897) of the old school states that staphisagria has been used most successfully in night sweats, in doses of two or three drops of the tincture in 2 oz. of water—a teaspoonful every two



hours, surely a very minute dose for an allopathic practitioner!

XV.—*Local and Surgical Uses of Staphysagria.*

It is not very well known to the homœopathic body that staphisagria ranks with calendula and hydrastis in the healing of wounds.

*Case 23.*—Dr. E. C. Franklin, a first-class surgeon of our American colleagues, applied staphisagria lotion to the wound after an operation for hypertrophy of the tarso-phalangeal portion of the foot, and it healed by first intention.

*Case 24.*—Dr. M. Macfarlan reports a case of gunshot wound of the chest of a serious nature; the ball, entering between the fifth and sixth ribs, passed out between the eighth and ninth, detaching a spicula of bone as it passed along the ribs. Per-sulphate of iron arrested the hæmorrhage, and staphisagria was given internally. He was able to attend to his business in fourteen days.

Dr. Clifton used it as a lotion for strumous ulcers, and the ulcers of bone disease in the strength of ʒj. of the tincture to 10 oz. of water, with success. He gave staphysagria 1 to 12 internally to these cases.

*Case 25.*—Dr. J. G. Gilchrist, U.S., records a case of rapid healing of a wound in the cornea from a chip of wood, involving prolapse of the iris. The eyelids were closed by plaister; acon. 30 was given every two hours for two days, followed by staphisagria 200, four doses per day. In ten days the eye was well, the iris replaced, and not the slightest cut noticeable.

Dr. Douglas Mitchell writes in the *Southern Journal of Homœopathy*, September, 1895: "This medicine, from 2x to C.M., will alleviate incised wounds in almost every case, whether from accident or operation. It is especially indicated after abdominal incisions where the patients complain of sharp, biting pains.

Dr. Constantine Hering relieved promptly with staphisagria the colic of a patient who had just been operated on for lithotomy, and thereby probably saved a life, for

this symptom after lithotomy is of very grave import. Probably staphisagria would be excellent if given after the operation for appendicitis.

The local tampon of animal wool soaked in glycerole of staphisagria tinct. by Dr. E. T. Blake merits mention here. In cases of pouched or prolapsed bladder, consequent upon rupture of the perinæum, Dr. Blake introduces about six of these tampons, strung upon string like a kite-tail, and packs them around the cervix uteri during forced expiration; then fills the whole vagina with wool, and applies a T bandage. The tampons are to be worn all day and taken out at night. This method has often so improved the patient's comfort as to do away with the necessity for perinæorrhaphy.

I have no space left to discuss delphinin, the therapeutic qualities of which have yet to be tested. Probably it will act in neuralgia just as aconitine does, but it will be found a milder remedy.

#### GENERAL SUMMARY.

Staphisagria is not a polychrest, but comes near to being one, if we can trust the genuineness of all the provings. It affects the skin with papular itching eruptions, and with subjective nerve-sensations. It produces amblyopia and inflammation of the eyelids; weariness and stiffness of all the limbs and joints, with pain, as if bruised, of the muscles; colic, nausea, vomiting, and an imitation of sea-sickness; inflammation of the bladder and irritation of the sexual organs in both sexes, but especially the male sex; sprained pain of the back; night sweats, sometimes foetid; an afternoon fever, toothache, faceache, and other neuralgias, mental languor, depression, and temporary loss of memory.

It is best suited to very sensitive and impressionable persons, and is more successful in chronic than in acute diseases, except in prosopalgia and odontalgia.

I hope that, from the twenty-two clinical cases cured by Staph. here collected, and the many therapeutic suggestions

offered, some small addition may have been made to our knowledge of and interest in *delphinium staphisagria*, which will bear fruit in practice, in further extending relief to suffering humanity.

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Dr. DYCE BROWN expressed the thanks of the Society to Dr. Murray Moore for his interesting and important paper, and for having come all the way from Liverpool to read it personally. He thought it was of great importance to have every now and then in the Materia Medica Section a paper such as the present. It had constituted an exhaustive survey, and however good one's knowledge of materia medica was, to hear such a paper as that just read refreshed one's memory, and brought the chief points more fully to notice. Besides its careful analysis of the pathogenesis, the paper was made much more practical by the number of cases given, with extracts from the journals showing its curative effects.

Dr. BLACKLEY felt himself to be under a great debt of obligation to Dr. Murray Moore for coming such a distance to read his paper. He (Dr. Blackley) had occasionally used staphisagria externally for scabies, but one did not see much scabies in skin work in London. In Manchester and Liverpool there seemed to be a good deal of it, and he believed that the further north one went the commoner the disease was found to be. He could not say it was so from his own personal knowledge, as he knew very little of Scotland. Still, Scotch students seemed to speak of scabies as if it were a very familiar condition. During the last twelve or eighteen months he had seen an interesting case of cure of facial neuralgia by staphisagria, and the hint had been very valuable to him. It was a clinical experience which he received at the hands of his friend Dr. Stonham. While he (Dr. Blackley) was away for his holidays Dr. Stonham took charge of the patient, an old lady whose age was now 87, who had infraorbital neuralgia, or what he took to be such. She had been a sufferer from it for several years. She had been to the dentist to have all her teeth extracted, and for a time she was free from pain; but on the above-mentioned occasion the pain returned with redoubled fury. It was pain similar to that mentioned by Dr. Moore, which was brought on by the slightest touch of food, of a spoon, or anything else in the mouth. He (Dr. Blackley) had tried various things, external and internal, but had never given staphisagria. Dr. Stonham, with his usual

care in the choice of remedies, gave her staphisagria 30, and it acted like a charm. The patient was never now without it in the house; it acted now quite as satisfactorily as it did eighteen months ago.

Dr. STONHAM said that, as Dr. Blackley had mentioned his name, he would like to state that he got the hint from reading Dr. Bayes' book, as the symptoms seemed to correspond so closely with those mentioned in that work under staphisagria. There was another use for staphisagria which Dr. Moore had mentioned, *i.e.*, for pain after wounds and operations. He had recently used it for severe pain in the neck following tonsillectomy. The patient had great pain, and could not bear the neck to be touched; he gave staphisagria 30, and it went away at once.

Dr. McLACHLAN said he had been much interested in Dr. Moore's paper. The only experience which he could add to the staphisagria discussion was the following. When he was a student at Edinburgh, in Dr. Argyll-Robertson's time, it was always taught that there was a difference between colazion and meibomian cyst, in other words, that a meibomian cyst was a retention cyst, whereas the colazion was a mere collection of cells due to a proliferation of cells lining the duct. The one could be shelled out fairly comfortably, whereas the other had to be scraped out with a small Volkman's spoon. He had seen it stated somewhere that colazion was nearly always cured by staphisagria. He had a lady patient in Oxford who had what he took to be colazion, looking like a hard body under the upper eyelid. She had staphisagria 6, and the cyst disappeared without the need for resorting to surgery. The cyst had been there for a long time, and her son, who had then begun to study medicine, made a great deal of the case among his friends, most of whom refused to believe it.

Dr. MURRAY MOORE, in reply, said he felt well repaid for his cold journey by the interest which his paper appeared to have excited. He wished he could induce Dr. Stonham and Dr. Blackley to write their particulars of cases, so that he could add them to his collection. He had collected together twenty-five cases in that paper, but the labour was not represented by that number. He had looked over 120 of the homœopathic journals, but had found but little to reward his search. That showed that the profession had not taken up the pathogenesis in any serious spirit. The reason of that, he thought, was that it was not included in the "Cyclopædia of Drug Pathogenesis," which he believed was now the recognised text-book. In studying Allen,

one should have the three editions—the Encyclopædia, the Handbook of Materia Medica and the Primer. If one was in a hurry and wanted some idea of *arsenicum iodatum*, for example, one took the Primer. If that was found to be too indefinite, one went to the Handbook, and that was generally found to give all that was required. If any particular symptom was required, one had to go to the large ten-volume work of Allen. He believed the art of prescribing was to pick out the most peculiar symptom of the case and work it from that. If his contribution had done anything to stimulate a study of materia medica, especially in that particular medicine, he should feel amply repaid.

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**SOCIETY NEWS.***The Dudgeon Memorial.*

ON the recommendation of the Council the Society has resolved to purchase an oil painting of the late Dr. Dudgeon by his son-in-law, Mr. Philip Stretton, R.I. To all subscribers of two guineas and upwards to the Memorial Fund a copy of a photograph of Dr. Dudgeon will be presented.

*Circulation of Foreign Periodicals.*

IN order that members of the Society who desire it may have the opportunity of early acquaintance with the leading foreign homœopathic periodicals, a scheme has been set on foot for the circulation of these publications by means of a magazine club. For the working of the scheme a certain number of members have to be obtained who will join the scheme, and a certain publication in single issues sent to each member to be retained for a short period and forwarded by him to the next name on the list in rotation. Arrangements for the first set of names and periodicals are on the point of completion as this note is sent to the Press.

**OBITUARY.***Dr. Eubulus Williams.*

The Society has lost a distinguished and kindly member in Dr. Eubulus Williams, late of Clifton, who died on the 9th of January last in his seventy-fourth year. Dr. Williams was elected a member of the Society in 1892. He was not often seen at the meetings in London, but was known to all the older fellows and members as bearing well a part in the representation of homœopathic practice in the West of England. Dr. Eubulus Williams was for many years physician to Müller's Orphanage in Bristol, and was President of the West of England Therapeutical Society from its formation until 1893.

*Dr. Conrad Wesselhœft.*

The late Dr. Conrad Wesselhœft was elected a corresponding member of the Society at the Annual Assembly of last year. He died on Dec. 17, in his seventy-first year. Dr. Wesselhœft was a German by birth, but his education and medical career were American and spent in Boston, Massachusetts. He was an eminent scientific homœopathic physician, his leanings being to the pathological aspect of therapeutics, rather than the symptomatological. He was physician to the homœopathic hospital of his native city, and held a chair in the University School of Medicine. Some years ago he conducted an important series of experiments on the trituration question. He was on the committee for the compilation of the *Encyclopædia of Drug Pathogenesy*. Many senior members of the Society will miss Dr. Wesselhœft as a valued and true friend.

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act until some indication called for a repetition or change of remedy. Dr. Cooper's observations extended from September, 1903, until March, 1904. Under previous treatment improvement did not appear to be marked until *scilla hyacinthoides* was given, and followed later by *hyacinthus romanus*. In August a report was sent that the patient was looking well, with a clear complexion, is bright and cheerful, and has gained in weight; "no lump can be felt." Dr. Cooper's suggestion is that the liliaceæ, as a whole, are indicated in these conditions.—(*Homœopathic World*, September, 1904, p. 395.)—ED.

**Kali Bichromicum.** *Glycosuria following acute poisoning.*—A woman took two to three tablespoonfuls of the solution used for charging a galvanic battery (consisting of a saturated solution of bichromate of potash and some sulphuric acid) with the intention of committing suicide. Vomiting occurred immediately, and somewhat later acute burning pain in the region of the stomach came on. Two hours later there was cold sweat, brownish-red tongue, frequent pulse and tenderness of the region of the stomach. The stomach was at once washed out, firstly with 40 litres of sterilised water and then with 3 litres of a 1 per cent. solution of nitrate of silver. White of egg was administered, but was immediately vomited up. An hour later severe collapse came on, with flickering pulse, loss of consciousness, and cold sweat. After hypodermic injection of camphorated oil, and a high rectal injection of 600 c.cm. of normal saline solution the condition gradually improved. On the following day the urine was found to contain 0·08 per cent. of albumen and 0·55 per cent. of sugar, with red blood cells and pavement epithelium. On the sixth day the urine was again normal and the patient cured.—(*Berl. Med. Wochenschr.*, November 28, 1904.)—J. G. B.

**Irrigation in Operation for Unripe Cataract.**—Dr. Kellogg, of Los Angeles, Cal., in an article on "Operation for Unripe Cataract," comments on the difficulty often experienced in extracting the whole of the lens when the cataract is not perfectly mature. Transparent lens substance is soft, easily parts from the opaque portion of the lens, and is left behind in the eye. This acts as a foreign body, causes iritis, and becomes itself opaque and may, in this way, replace the original cataract as an obstruction to vision. The ordinary method adopted to get rid of lens substance left behind by that of "milking" the eyes, by bringing alternate pressure and relaxation to bear on the cornea he found to be both clumsy and unsatisfactory, and was led to try instead a method



first introduced by McKeown, of Belfast—that of irrigating the eye. The irrigating fluid consists of a normal saline solution, sterilised and at body temperature. This is placed in a wash bottle. A double bulb, such as is used with the Paquelin cautery, is connected with a glass tube introduced through the cork, and the solution is forced out through another glass tube connected by rubber tubing with the syringe point. The latter is of silver and flat at the extremity to admit of ready introduction into the incision. The flow is regulated by means of a silver plate at the other end of the nozzle over which the tube is passed, and against which it can be compressed. After the nucleus of the lens has been extracted in the usual manner, the nozzle of the syringe is inserted through the incision, to a point just inside the anterior chamber. The stream is then allowed to flow with a very slight amount of force into the anterior chamber, finding its exit through the incision. The residual lens matter is in this way washed out. It is advisable to continue the process some time after the pupil is apparently clear, in order to make sure of leaving no transparent lens substance behind. No harm is done to the eye through the carrying out of this procedure.—(*Pacific Coast Journal of Homœopathy*, August, 1904.)—T. G. S.

**Mercurius Iodatus in Goitre.**—Dr. Jos. M. Diller has found mercurius iodatus far more efficacious in eradicating goitre than any of the other remedies recommended by our authors. He uses the 1x trit. in half-grain doses together with an external application of an alcoholic solution of iodine of the strength of ten drops to the ounce, and with the happiest result.—(*The American Physician*, October, 1904.)—T. G. S.

**Methyl Alcohol. Poisoning.**—The symptoms of methyl alcohol poisoning are: Great muscular weakness with defective heart action, followed by intense gastro-intestinal disturbance with severe nausea and vomiting, intense headache, giddiness, coma and delirium. Some cases recover only to find that they are nearly or totally blind. Some do not lose their sight for several days after they have recovered from their intoxication. These cases of blindness may improve under treatment, but nearly always relapse. On examination there is found a contracted visual field with absolute central scotoma. The pupils are widely dilated and irresponsive to light. Ophthalmoscopically there is noticed a blurring of the edges of the optic discs, positive optic neuritis, and later optic atrophy.—(*Pacific Coast Journal of Homœopathy*, December, 1904.)—T. G. S.

**Negundium Americanum in Hæmorrhoids.**—Dr. O. S. Laws recommends *Negundium Americanum* or Box elder in engorgements of the rectum and piles with great pain. He gives eleven drops of a tincture made from the root and twigs, every two or three hours till relief is obtained.—(*Pacific Coast Journal of Homœopathy*, December, 1904.)—T. G. S.

**Plumbum.—Eye Symptoms.**—A type-setter, aged 37, who handled lead type for ten hours daily, complained of an unusual blur before his left eye. Test of vision was : Right eye, 20/30 + ; left eye, 20/40 +. The left pupil was slightly dilated, but reacted freely to light. The field of vision presented a scotoma, downward and inward, sector shaped, apex at 10° from the point of fixation and 30° wide at the periphery. The fundus showed a slight veiling of the disc and a small retinal hæmorrhage above the disc, and a little to the temporal side. The hæmorrhage and consequent œdema of the adjacent retina were the evident cause of the scotoma. After a week of rest on light diet and *Apis* 3, his vision, with correction for a low degree of astigmatism was : Right eye, 20/20 + ; left eye, 20/30 +.

A subsequent attack of typical lead colic revealed the cause of his ocular troubles. He occasionally drank water acidulated with dilute sulphuric acid, and four months later the fundus and field were quite clear and vision in each eye was normal.—(*North American Journal of Homœopathy*, December, 1904.)—C. J. W.

**Prophylaxis by Drugs.**—Dr. J. C. Guernsey gives a list of drugs which, when used in the potentised form, he has found efficacious as prophylactics for various diseases. They are aconite, to prevent colds developing after exposure to dry, cold air ; *apis* 40 m., to cut short styas and felons ; argentum nitrate, to prevent ills arising from excessive eating of candy and sugar ; *coffea* 200, to prevent sleeplessness and palpitation after drinking coffee at night ; *nux vomica*, to prevent gastric derangement after a big meal ; *arnica*, to prevent evils from falls or blows, especially if on the head ; *arsenicum* 30, to prevent ills arising from a stay by the sea-shore ; *baryta-iod.*, to extinguish quinsy when symptoms first appear ; *belladonna* 30, to abort a boil on the back of the neck ; *bryonia*, to abort typhoid ; *china* 30, to ward off chills and fever occurring in a malarious district ; *gelsemium*  $\phi$ , at the beginning of a cold to break it up ; *hypericum*, to prevent lockjaw after a punctured wound ; *pulsatilla* 30, to prevent a mal-presentation in labour, given at the onset ; *rhus tox.*, to prevent evil results from getting wet. — (*Hahnemannian Monthly*, November, 1904.) — T. G. S. (See Summary, JOURNAL, vol. xii., p. 438.)

**Sabadilla.** *Poisoning.*—J. Mayer records the following case of poisoning in a workman who had taken a tablespoonful of sabadilla seeds with suicidal intent. When seen half an hour later the appearances were as follows: Countenance livid and covered with sweat; respiration quickened, deep and panting; pulse 90, strong and regular; there was a state of psychical irritation; the patient struck out with his hands and abused a bystander. Somewhat later an apathetic condition came on, so that the stomach-tube could be used, and this was followed by copious vomiting. On the following day the patient complained still of slight burning in the mouth, gullet and stomach, also of a prickling sensation in the lips, and these, as well as the tongue, felt as if made of wood, and appeared to him enlarged. In the night he had repeated spasmodic contractions of the left *pectoralis major*. Presently the pulse had fallen to 38 in the minute and was of low tension; the cardiac movements became sluggish and wanting in vigour, and, on palpating over the site of the apex-beat, a very slow dilatation and contraction of the heart-muscle could be distinguished. Sensation was manifestly diminished; some of the reflexes were lessened, others absent. Pupils slightly dilated and reacting sluggishly. The symptoms gradually disappeared, but, even on the sixth day, on attempting to walk about, he had a fainting attack. The quantity taken was about 15 grammes, containing 0·3 to 0·4 per cent. of veratrin.—(*Prag. Med. Wochenschr.*, 1904, No. 26.)—J. G. B.

**Sinapis.** *Poisoning.*—Dr. Kolbe observed a woman who, for four days, had taken five or six heaped teaspoonfuls of mustard seeds for pains in the stomach. She was found unconscious, with a rapid pulse and abnormal temperature, contracted pupils, and respiration diminished (3 to 8 in the minute). The urine contained albumen and 5 per cent. of sugar.—(*Deutsche. Med. Woch.*, No. 7, 1904. *Hahnemannian Monthly*, October, 1904.)—C. J. W.

**Stellaria Media.** *Proving.*—The University of Michigan Society of Provers have proved *stellaria media*, or chickweed, in doses of the tincture to the third decimal. A summary of symptoms in schema form is presented by Dr. A. E. Ibershoff, and the following general conclusions: *Stellaria media* appears to have a small but well-defined sphere of action. It induces a condition of stasis and congestion, and the accompanying sluggishness of all functions characteristic of the constipation diathesis, coupled with intermittent rheumatoid pains. Its

head, stomach and bowel symptoms all point to congestion; the morning aggravation and conditions of amelioration and increase being almost identical with those of *nux vomica*, while the rheumatoid manifestations, their relief from motion and aggravation from warmth, resemble more closely those of *pulsatilla*. There was apparently no definite relationship between the size of the dose given and the severity of the symptoms which ensued, largeness of dose leading rather to promptness of effect. The provers of sluggish habit appeared to show more susceptibility to the drug. One prover who had been suffering from constipation experienced aggravation at first, and then amelioration up to the occurrence of diarrhoea. Careful examination of the urine and blood failed to elicit any alteration, and the urinary and generative spheres appeared unaffected by the drug. (*Homœopathic Recorder*, September, 1904, p. 399.)—ED.

**Tabacum.**—Dr. Searson draws attention to the homœopathicity of *tabacum* to a condition probably not usually thought of as calling for the drug, namely, the symptoms associated with the pathological state known as arterio-sclerosis. In the case of an elderly gentleman who had intermittent and feeble action of the heart, great pallor, breathlessness, nausea with occasional vomiting, uncomfortable feeling at the epigastrium, headache and giddiness, with a hard, cord-like pulse, *tabacum* 6 had an almost magical effect in relieving all the symptoms.—(*Homœopathic World*, November, 1904, p. 492.)—ED.

**Veronal.**—*Effects upon the Skin.*—Davids relates the following peculiar and hitherto unrecorded effect of veronal, a drug which has of late been used so largely as a hypnotic, and usually without any unpleasant effect. To a patient suffering with a serpiginous ulcer, 1 grm. of veronal was administered at bedtime. Next morning, whilst being led along a corridor, she suddenly fell down. She did not answer when spoken to; the pulse was found to be irregular, and the skin of the chest, hands, forearms and legs, were covered with a vivid erythema. When roused by shaking the patient scratched herself, and then fell once more into a sleep which lasted all that day and the following night. The redness, which disappeared on pressure, lasted two days, and then faded slowly up to the tenth day, when it was succeeded by copious, scaly desquamation, especially on the hands and feet.—(*Berl. klin. Wochenschr.*, 1904, No. 31.)—J. G. B.

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ABDOMINAL EXAMINATION AND PALPATION  
DURING PREGNANCY AND LABOUR.

PRESIDENTIAL ADDRESS<sup>1</sup>

BY JAMES JOHNSTONE, B.A., M.B., F.R.C.S.

*Assistant Physician for Diseases of Women to the London Homœopathic  
Hospital.*

THIS year a somewhat unusual course has been adopted with regard to the Presidential address. Under ordinary circumstances it falls to the lot of the President to begin the work of the session at the first meeting by a more or less lengthy address. Owing to the death of our late esteemed colleague, Dr. Dudgeon, to whose cherished memory we now contemplate erecting a tangible memorial, the Presidential address was postponed to a later date, and, as the subject chosen was somewhat of a special and technical nature, it was deemed advisable to fit it into a vacant niche in a surgical and gynecological evening, and I shall now proceed, with your indulgence, to fill up that niche.

<sup>1</sup> Presented to the Section of Surgery and Gynecology, December 1, 1904.

But, before doing so, may I once more be permitted to tender my sincere thanks to the Society for the great honour they have done me in placing in my hands this session the reins of the chief office. I feel all too unworthy of the honourable task thus entrusted to me, but, with the assurance of the hearty co-operation of my colleagues in office, of the Council, and of you as individual members of the Society, it is my hope that the work of the Society during this session shall at least maintain the high level of interest and utility at which my predecessors in office have hitherto contrived to keep it.

I believe I voice the feeling of your past Presidents of recent years when I say that it is a somewhat difficult problem to discover for the annual address a subject with the charm of novelty and of universal interest to the members. In abandoning the search for a subject of general interest, I naturally turned to something which specially commends itself to myself, but which, I trust, will also appeal to that large section of the Society who are engaged in more or less general practice.

The practice of midwifery has, we know, not been encouraged by many of our general practitioners in the past, and, even at the present day, I believe there are many of our best therapists who prefer to devote their attention solely to the medical ailments of suffering humanity, leaving surgical and parturient sufferers to the care of others, by whom, in many cases, opposing views in therapeutics are held. One cannot help feeling that this procedure must be somewhat disadvantageous to the interests of homœopathy. We know of no link that binds the family physician more closely to his patients than that of having watched over their interests at birth.

It is round this link that my subject this evening centres.

Not very many years have elapsed since I studied at the feet of an eminent and successful obstetrician. Yet I can remember that little or nothing was taught of the examination abdominally of a woman before or during labour. The result is that the majority of those who have been in the practice of midwifery a few years know nothing of the

condition of labour cases until they are called, as is the usual practice, when labour has been in progress some hours. When the practitioner arrives in the lying-in chamber, he finds, as a rule, various customary preparations made by the nurse or attendant. The patient is usually lying on her left side with knees drawn up. The first procedure on the part of the average obstetrician, after a more or less perfect washing and disinfection of the hands, is to make a vaginal examination. This is repeated at varying intervals during the progress of labour, and all information as to the nature of the presentation and configuration of the mother and foetus is derived therefrom. Usually it is not till the os is fairly dilated that the presentation is made out, a stage at which the labour is well under way and change of the presentation a more or less difficult and risky matter. The more difficulty there is in the diagnosis of the presentation, the more protracted the labour, and the more nervous or hurried the medical man, the more frequent are the examinations. We know from the bacteriologist that each vaginal examination, however carefully and antiseptically conducted, is fraught with danger of sepsis to the mother. The normal vagina and uterine cervix are now found to possess in themselves natural safeguards against infection from without. Vaginal examination only tends to destroy these safeguards, and, therefore, the less frequently examination is made, the better for the future welfare of the mother.

The other danger, at which I have already hinted, is the discovery, rather late, of some abnormality in presentation or formation of the parturient canal, which an advanced degree of labour makes difficult of rectification. By a vaginal examination, and that even under very favourable conditions, only a small part of the foetus, namely the presenting part, can be reached by the tip of one or two fingers. The knowledge thus obtained is usually very restricted, and, therefore, very incomplete. Moreover, deformities of the pelvis are often unsuspected till labour has become protracted, the patient exhausted, and valuable time wasted.

It is little wonder that the conduct of labour under these conditions, where the anatomical conditions and relations



are comparatively unknown, and unpleasant surprises are lurking at every corner, has become a nightmare and a dread to many a good physician, particularly in the days when, in addition, antiseptics and asepsis were entirely unknown or imperfectly understood.

But recent years of obstetrical research and observation have provided a better way by the introduction and development of abdominal palpation as a routine in the conduct of labour, and, of more importance still, as a precautionary measure during the later months of pregnancy. While we in this country claim the honour of having been pioneers in the discovery of two of the greatest benefits to parturient women—anæsthetics and asepsis, we have left it to our neighbours on the Continent and over the water in America to work out and perfect the third great benefit, namely, an early and accurate diagnosis of the condition and relations of the foetus and of the maternal organs involved in delivery. It is only in a few of our large lying-in hospitals that this procedure is paid much attention to, and only one or two of present-day text-books for midwifery devote more than passing attention to so important a subject.

By the employment of careful and practised abdominal palpation in the later months of pregnancy (and I use the word "practised" advisedly, for this, like all other manipulations, requires practice to get the most out of it), it is possible to make out the condition of the uterus, the position and presentation of the foetus, to discover abnormalities in the liquor amnii, the configuration of the bony pelvis, the presence of such complications as abdominal tumours, and many other conditions which would come as a surprise when discovered late in the progress of established labour, *conducted by vaginal examination* alone.

What a relief it is to the medical man to examine a pregnant patient at the seventh or eighth month and find that everything is in normal condition, and what a greater relief it is to the patient and her friends to be told that thus far all is in good order, and that everything bids fair for a safe and uncomplicated labour! Of still more value than reassurance to physician and patient is the early discovery of



abnormalities for the correction or efficient dealing with which prophylactic measures may be adopted. Yet such is what may easily be done by anyone who will devote a little practice to the acquisition of this most useful means of acquiring definite knowledge.

It is not too much to say that the abdominal palpation of the abdomen in the later months of pregnancy when possible, and certainly without fail at the onset of labour, is the duty of every honourable accoucheur. No less than it is the absolute duty of the surgeon to take antiseptic precautions in the conduct of any operation, however trivial. Prophylaxis is the first step in scientific obstetrics.

I shall now proceed to put on the screen a series of pictures illustrating the subject.

First of all I will show a picture (fig. 1) indicating how this palpation of the abdomen should be proceeded with, and how one must prepare the patient, who should, if possible, be lying on the back on a bed or a couch. The abdomen ought to be bare, or one thickness of some thin material may be spread over it. A very special point is that the hand should be made warm, in order to prevent any undue contraction of the abdominal muscles or of the fundus of the uterus. Most observers prefer to have the knees slightly bent. It is necessary to empty the bladder and rectum thoroughly, so as to leave the lower abdomen free for the uterus and its contents. Then is to be observed the general condition of the patient; an examination of the lungs, heart and kidneys should be made, and also an examination for traces of syphilis, tuberculosis, and other constitutional diseases. Next, attention should be given to the condition of the nipples and the breasts. The first uterine observation should be as to the general trend of the uterine axis, noting whether the uterus is in the middle line or inclined more to one side or another. Then the condition of the abdominal walls should be determined, particularly whether they are thick or thin, the amount of fat, whether pendulous or tense, and the tone generally of the muscles of the abdomen which play a very important part subsequently in the later stage of labour. In addition, some

estimate must be made of the amount of the liquor amnii in which the foetus is floating.

The palpating of the gravid uterus with the flat of the hands, one hand on either side, in order to make out the foetal parts, is the next procedure. One is thereby enabled to determine on which side the back of the foetus lies. Many of you, I daresay, will think this is rather difficult, but, after practice, you will find it is quite easy. If you palpate each side of the abdomen with a flat hand, you will



FIG. 1.

Palpation of the dorsum and small parts.

find that one side, as a rule, gives a certain amount of resistance, and conveys to the hand the feeling of a broad, smooth surface. On the other side you get a feeling of fluctuation, with the presence in the fluid of many small parts, resembling little fibroid tumours, more or less detached. The side on which the broad surface is will be occupied by the back of the foetus, and the small parts will be on the abdominal aspect of the foetus.

The next manoeuvre is to determine the contents of the lower abdomen. Setting aside the suggestion that, as a rule, presentations are in the normal position, we want to know what is to be found at the lower pole of the foetus. The manoeuvre required is the placing of a flat hand (fingers pointing downwards) on either side just above the pubes, feeling for the brim of the pelvis, and palpating anything that may come between the two hands in that position. Generally it is found that a rounded mass, corresponding to the head, lies there. The head can be felt quite easily when in this position by gently bringing the hands together. In doing this, it is well not to place the hands



FIG. 2.

Palpation of lower pole of foetus, the tips of the fingers pressing inwards above the brim of the pelvis.

perfectly flat upon the abdomen, but rather to curve the fingers in somewhat vertically above the pelvic brim, and it is astonishing how easily you are able to outline the head in that position.

Fig. 2 shows the manoeuvre referred to. The accoucheur is standing above, face directed toward patient's feet, and pressing his hands into the lower part of the abdomen just above the pelvic brim, and there palpating the head.

The next movement is the palpation of the upper part of the abdomen, where usually the breech is to be found, less frequently the head.

Fig. 3 shows the method of feeling the fundus. It is performed by facing the patient, passing the hands over the top of the fundus and approximating them, and then pressing in the fingers and feeling gently for the contents of the uterus. Here in outline you see the foetus lying with the breech at the fundus, the dorsum on the left, and the small parts on the right-hand side of the patient. The breech presents different characteristics from those of the head; it is a more diffuse mass, not so hard or rounded, and

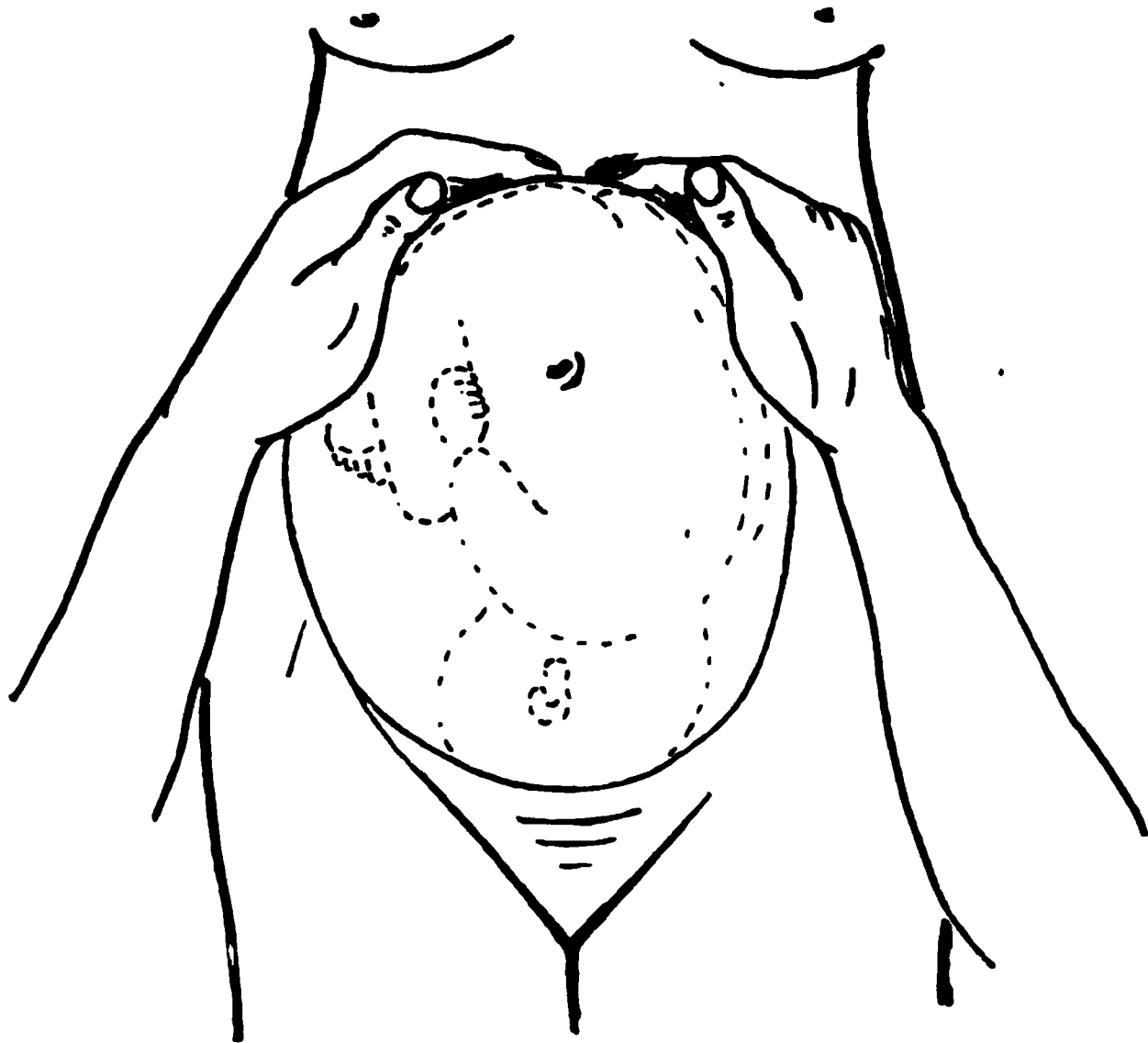


FIG. 3.

Palpation of the upper pole of foetus.

one is unable to ballot it between the hands; it does not move to and fro as readily as the head does when in that position.

Different observers adopt different methods. It is well in making abdominal palpation to proceed in a regular manner, in order that one may classify the information obtained from the examination. There are two leading methods: one is the method devised by Leopold, and the other that by Pinard. By Leopold's method one begins at

the fundus with what he calls his first grip. Facing the patient, he takes a firm hold of the upper part of the abdomen and, with fingers directed upwards, palpates the fundus of the uterus and its contents.

Leopold's second grip (fig. 4) is made with the hands on the sides of the abdomen as before, fingers pointing to fundus, palpating the dorsum on one side and the small parts on the other.

The third grip (fig. 5) is made with one hand. The fingers on one side and the thumb on the other are thrust

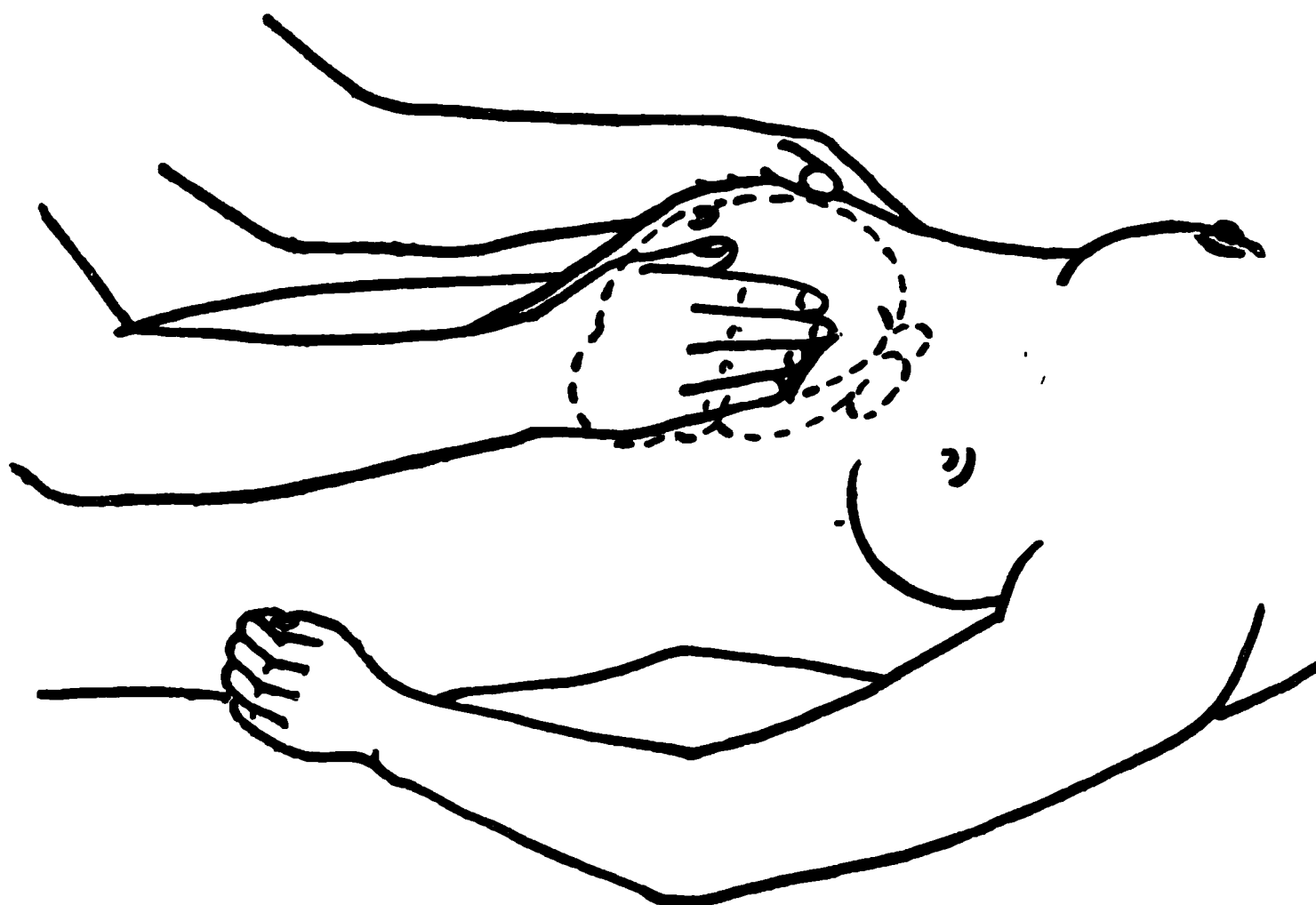


FIG. 4.

Leopold's second grip.

into the lower part of the abdomen just above the brim of the pelvis, and there, if present, the foetal head or breech can be easily felt.

Another grip for the lower part of the abdomen is made by standing above the patient and pressing the fingers and thumb down very much in Leopold's way.

The other method of procedure is that of Pinard, who advises always beginning from below, in contrast with Leopold's beginning above. Pinard says that as the normal place for the head is below, it is better to take the

easy point first. If once you determine the position of the head, then the rest is simple. Pinard's first grip (fig. 2) is palpation of the head at the pelvic brim. You will notice that when the head is presenting at the pelvic brim, the fingers, with points downwards, do not require to be pushed very far inwards. By making a slight indentation in the skin, the head falls naturally between the

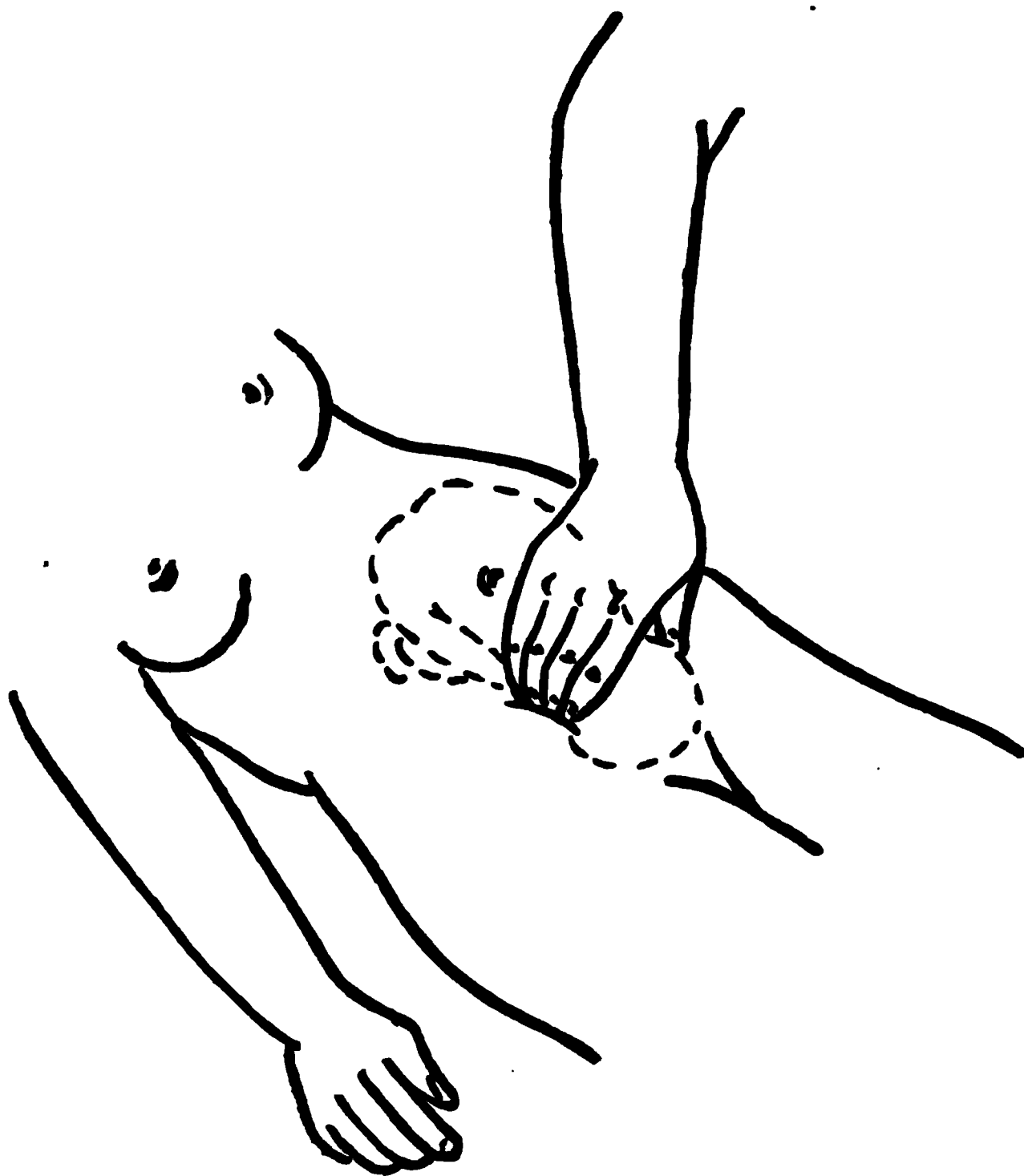


FIG. 5.

Leopold's third grip ; grasping the head with one hand.

fingers. That is one condition that you will find at the brim, *i.e.*, you find the head there.

An alternative finding at the brim obtains when it is possible to push the fingers deeper into the pelvis, between the foetal pole and the brim of the pelvis. Such being possible, it is almost certain that the breech is presenting and not the head. The breech does not fit the pelvic brim

so well as the head. As a matter of fact, the head is generally engaged in the pelvis, especially in a primipara, so that if you are able to push your fingers inwards you may safely conclude it is not a head, but most probably a breech presentation.

The third alternative at the brim occurs when it is possible to make the two hands almost meet across the middle line through a double thickness of the abdominal wall, the tips of the fingers going well into the pelvic cavity. In such a case there is no breech, there is no large

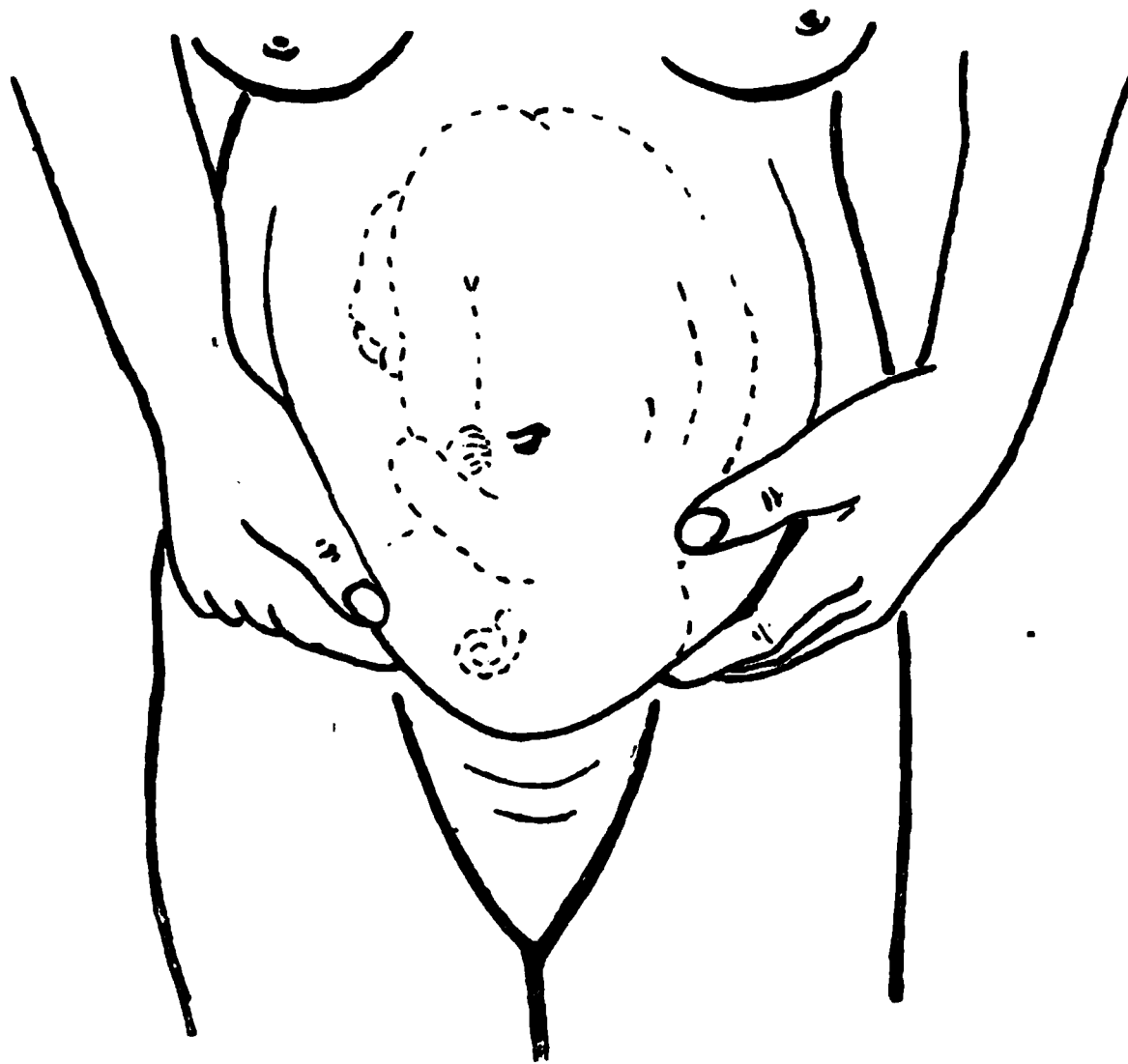


FIG. 6.

Condition found in contracted pelvis; lower foetal pole (head) tilted forwards on pubic ramus; tips of fingers meeting below the foetal pole.

mass to be found; and in that case, where there is no large foetal part in the pelvis, the probability is that the presentation is transverse. Those are the three alternatives which Pinard insists upon deciding before proceeding to examine the rest of the abdomen.

A somewhat rare fourth alternative presents itself when, though feeling the head at the brim, the fingers of opposite hands almost meet together (fig. 6). Here it is evident that something is preventing the head from entering the pelvis.

Such a condition is nearly always indicative of contracted pelvis, and the head prevented from slipping into the pelvic brim lies outside and above. In such a case you are able to get your fingers to meet almost across, and yet to have between and above them the foetal head.

The condition which obtains when there is a contracted pelvis may be thus explained (fig. 6). One generally gets a pelvic narrowing from before backwards. The head comes down upon a somewhat narrow opening which it cannot pass, and, unable to fall backwards owing to the promontory of the sacrum, it tends to tilt forward out of the pelvis. On examination it is found that the rounded head projects over the pelvic brim, pushing the soft parts before it. When

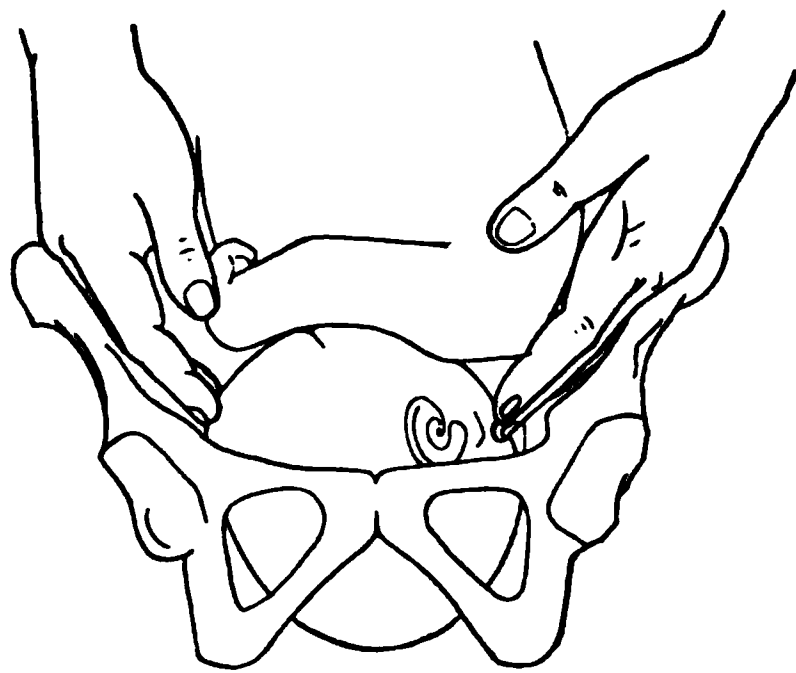


FIG. 7.

Determination of right or left occipital presentation by palpating occiput and frontal eminences and distinguishing between them.

such a condition is found on palpation one may say with almost certainty that the condition is one of contracted pelvis, and that, too, without any vaginal examination.

An additional point in diagnosis of conditions obtaining at the brim is the possibility of being able to determine the difference between the occiput and the frontal prominence. This is done (fig. 7) by pushing the hands as far underneath the head as it is possible, and estimating the difference and prominence between the two sides. As a rule the occiput lies towards the right or towards the left. We in this country map out four occipital positions, as if these



positions were in the four quarters of a circle, but on the Continent they only recognise two positions, a right or left position. Whether the occiput is a little to the posterior or anterior does not make much difference ; their main distinction is between right and left, a distinction very much simpler than ours, which is unnecessarily complicated. As I have said, it is possible by delicate palpation to determine the occiput and the forehead. On the occipital side it is possible to get the fingers very much further down into the pelvis, and you may get as far as the groove of the neck. On the other side, that of the forehead, the fingers do not go down quite so far into the pelvis, you have no groove above such as you have on the neck side, and there is a broad, smooth surface. These conditions enable you to say almost with confidence that you are palpating the forehead. The other side must, of course, be the occiput. It looks perfectly plain in the picture, but when you have the abdominal and uterine walls overlying the foetal parts, you must depend, not on your eyes, but on the points of the fingers, and the *tactus eruditus*. It can be done by diligent practice, thus rendering it possible, and even easy, to determine the presentation from the abdomen alone, without any vaginal examination whatever.

During labour, examinations of the head may be made from time to time as it proceeds further into the pelvis. By this time you may infer that the os is dilating, and so, without making a vaginal examination, you may know that the foetus is in normal position, that the occiput is coming down and rotating, and you may know on which side you may expect it.

To corroborate the finding one should always resort to measurements of the pelvis. It is very easy by comparative measurements of the pelvis to determine in reference to a scale whether the pelvis is contracted or not, and the nature of the contraction. Some of you no doubt made such observations when students, but few, I venture to say, employ pelvimetry in practice. Its value was impressed on me very much last year when I was in Vienna spending a month's holiday at hard work in the obstetrical and

gynæcological wards of the general hospital. As a routine in every labour case, accurate pelvic measurements were taken, then careful abdominal palpation was carried out, and finally vaginal examination. By this means every possible piece of information was forthcoming, and an accurate picture formed of everything concerned in the labour.

It was particularly interesting to note how information gained by pelvimetry was confirmed by palpation or vaginal examination, or by both.

Everything was done thoroughly in each case; all data were carefully recorded, and cases indexed, so that if ever a patient turned up again for subsequent confinement, as was common in contracted pelvis, the obstetrician on duty had a complete record of previous confinements.

There is one other condition besides that of contracted pelvis which prevents the head from engaging in the pelvis, namely, placenta prævia, or the presence of the placenta in the lower part of the uterus. It is possible by palpation to localise the placenta, which is indicated by an area where it is not so easy to feel the foetal parts, an area corresponding in size and contour to the placenta. In the majority of cases the placenta is attached in front of the fundus; less usually it is attached at the back, very rarely at the fundus itself. If there is placenta prævia, it is absent from its usual position and is found well down in the pelvis near the os, where it interferes with the engagement of the head, and thus is one of the causes of the head not engaging in the pelvis. The two conditions, therefore, which prevent the head from engaging are contracted pelvis and placenta prævia. How is one to distinguish between the two? It is simple enough. In placenta prævia you have had in all probability the additional and characteristic sign of repeated hæmorrhage. In contracted pelvis this sign has been wanting. A combination of the two obstructive conditions must indeed be rare.

Various other abnormal positions of the foetus lend themselves readily to determination by abdominal palpation. Fig. 8 indicates the relation of the parts in shoulder presentation.

It is not very difficult by abdominal palpation to determine twins. Of course there may be found two vertices and two breeches, but the most easily noticed feature is the distinct groove usually running over the surface of the abdomen on either side of the middle line.

Another important manoeuvre where you have a normal condition of the vertex at the pelvic brim is to determine, not only the relative positions of right or left, but whether the occiput is anterior or posterior. This is done by

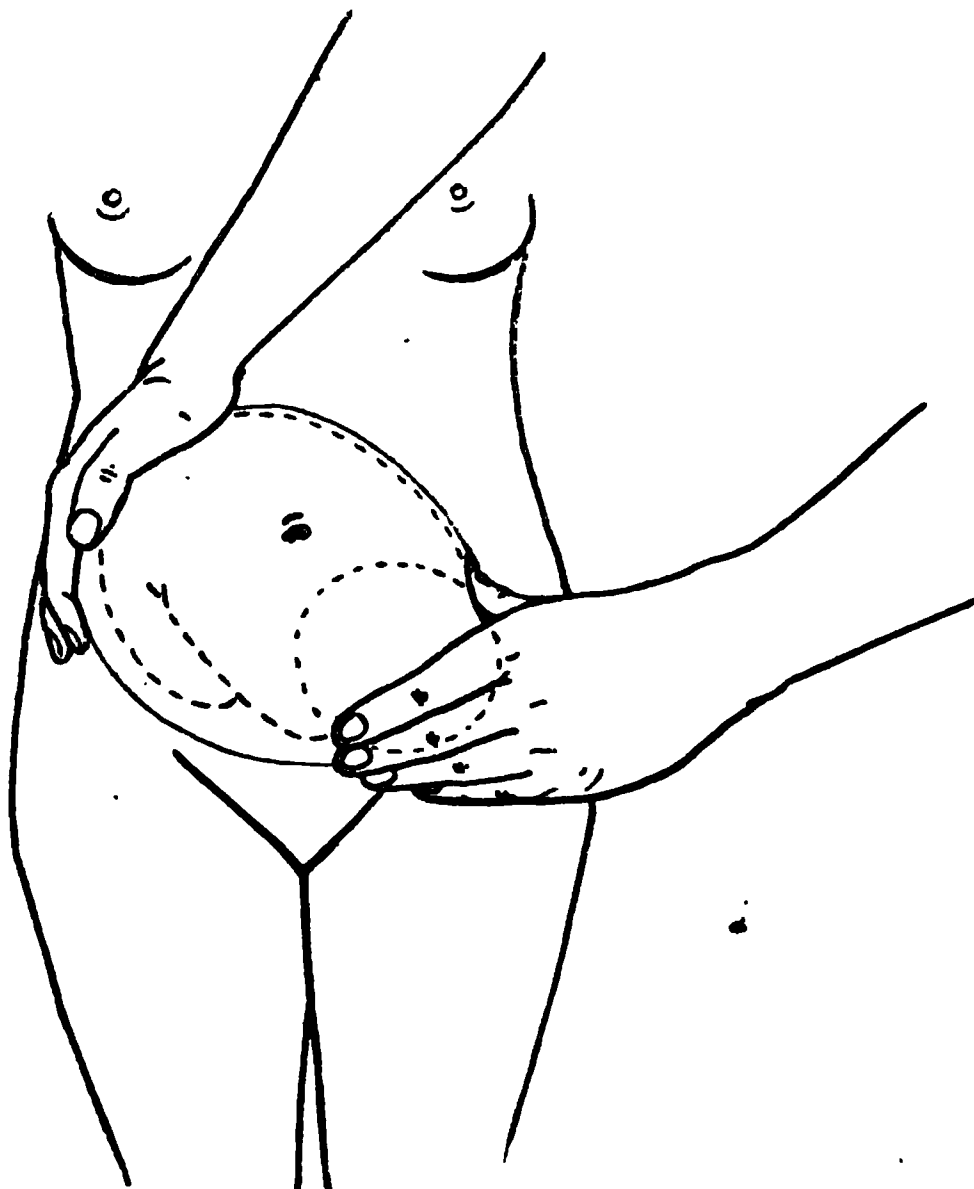


FIG. 8.

Palpation of breech and head in shoulder presentation.

examining for the anterior shoulder. If you are able to find the anterior shoulder near the middle line, or within two inches of the middle line, you can say it is an occipito-anterior presentation; if the anterior shoulder is more than two inches away from the middle line, then it is occipito-posterior, right or left as the case may be.

Another point of interest in abdominal palpation is to determine the position of the uterus itself, without regard

to its contents. The uterus takes various positions. You may have a symmetrical uterus where it lies exactly in the middle line. The round ligaments run down on either side, and it is quite possible under favourable conditions to make them out. It is even possible to feel an ovary, one or the other, or both, and occasionally the tubes. We find very often in a symmetrical uterus a rotation of the uterus with its contents, that is to say, the round ligament appears more on the left side and disappears on the right. In addition to rotation you may have a bending of the organ to right or to left. All these anatomical variations of position can be discovered by palpation.

In addition to palpation, other examination can be made of the abdomen. One source of accessory information is examination for the position of the foetal heart sounds. First of all, though we can hear these sounds either with the intervention of an instrument or by the ear itself applied to the abdomen, a very important point to be observed is that hearing is made easier when the surface of the skin is pressed down as near to the uterus as possible, thereby expressing anything that may be lying between skin and uterus, and allowing the ear to get as near as possible to the surface of the uterus. Under such conditions the foetal heart sounds are best heard. An additional improvement is gained by pressing downwards with a hand on the upper part of the uterus so as to push it forwards and downwards, thereby opposing it to the abdominal wall. This manoeuvre helps considerably. Then we ought to listen for the point of greatest intensity. If we find that the greatest intensity of the heart sounds is found below the umbilicus, we know that we are dealing with a vertex presentation. If, on the other hand, the intensity of the heart sounds is greatest above the level of the umbilicus, we are dealing with a breech presentation, the vertex being up at the fundus of the uterus. There are various refinements of this. Some enterprising German observer has gone so far as to attempt to diagnose the anterior and posterior occipital presentations by making out the points of greatest intensity of the foetal heart

sounds. This seems a little refined, but, if you give it some practice and attention, and work it out for yourselves, you will probably get more information from it than appears possible at first sight.

Flexion or extension of the foetus is found to influence the intensity of the heart sounds. When the foetus is somewhat bent on itself, so that the dorsum is arched and prominent, naturally over that part you will hear the foetal heart sounds most distinctly. A similar condition may be produced by an acute extension of the foetus, particularly in a face presentation, where the head and the limbs are thrown back and the chest is opposed to the abdominal wall. In that case the front of the chest will give us the area of greatest intensity, a condition not common, as generally the foetal heart sound is heard from the dorsum of the foetus. Thus, to infer the position of the dorsum from the point of greatest intensity might, as in the case cited, lead us into error.

In order to tabulate and collect all the information gained by abdominal palpation, it is well to have a diagram to record one's observations, and a simple sketch diagram gives all the information required. When palpation indicates a normal position, the vertex would be indicated by a full curve at the pelvic brim, engaged more at one side than the other to indicate the occiput, the less engaged side to indicate the brow and face of the foetus. The breech is represented by a broken curve at the fundus, the dorsum by a half curve on one side, while on the opposite side ovals and small circles denote the small parts, the feet, knees, elbow and shoulder. The anterior shoulder near the middle line would be indicated by a cross. The area of greatest intensity of the foetal heart represented by a series of concentric circles. The contour of the uterus, its rotation or flexion, the round ligaments, ovaries, placenta, &c., would be indicated by suitable lines. Such a diagram, carefully filled in, is a great help to accurate diagnosis.

Abdominal palpation also gives us information with regard to abnormalities inside and outside the uterus which are not at all uncommon. Myomata in the uterine wall are

often discovered in the last stage of labour when compressing the uterus for expulsion of the placenta. When small they give rise to no complications, but a large myoma, interstitial or submucous, might have a very serious effect in the course of labour. To determine its presence at an early stage would be of considerable advantage to the patient and the accoucheur, and in most cases could be easily done by palpation.

As an example of another complication may be mentioned the pushing of the uterus to one side by an ovarian tumour, situated low down in the abdominal cavity. The advantage of palpation of the abdomen before labour is very evident in a case of that kind.

Those who have exploited this abdominal method of palpation have claimed a great deal for it; they have claimed almost everything. Of their principal claims the first is, that there is no chance of any vaginal infection, a very valid claim. A claim less valid, especially in the country to which these observers belong, is that "modesty is not aggrieved," and that it is possible to conduct a labour throughout without subjecting the patient to the distress occasioned in mind as well as body by an examination *per vaginam*. The third claim is that by conducting a labour entirely by means of abdominal palpation there is not any risk of an early rupture of the membrane, a risk to be studiously avoided in certain conditions. Another advantage is that the palpation is easily practised; anyone can learn it if he will only set himself to try. Also it is claimed that the presentation and the position of the foetus can be diagnosed long before anything can be made out by a vaginal examination, and that the subsequent changes during the progress of labour may be accurately made out and interpreted. An advantage is afforded from the fact that abnormalities in the foetus, intra- and extra-uterine, can be discovered early, and that means can be taken for early rectification or treatment. And yet another very important advantage may be adduced, especially applicable in districts where rickets are common, *i.e.*, that errors due to contracted pelvis can be early diagnosed, even months before labour, giving ample time for prophylactic measures.

The conditions in which the purely abdominal examination is wanting are not very many. It is impossible by palpation alone to determine a prolapse of the cord. Also it is impossible to determine vertex presentation complicated by a hand; it is impossible to determine œdema or prolapse of the anterior lip of the cervix, which sometimes is a considerable bar to the progress of labour. Small prolapsed uterine polypi and other uterine tumours and tumours in Douglas's pouch cannot be diagnosed by palpation; it is only by a vaginal examination that such can be done. Exostosis of the sacrum cannot be discovered, nor can a rare condition of narrowed pelvic outlet which occurs in osteomalacia. Lastly, it is impossible to determine placenta prævia, where it lies posteriorly, except, of course, by the clinical symptom of hæmorrhage.

So much for the advantages and disadvantages of the abdominal method. What, it may be asked, are the disadvantages of the vaginal method? The salient disadvantage is an open door to entrance of sepsis into the parturient canal. A great many observations have been made with regard to the bacteriology of the vagina, the cervix and the cavity of the uterus, and it has been found that a normal vagina, either in a pregnant or a non-pregnant woman, has the faculty of disinfecting itself, or to make itself aseptic. There is found in the normal vagina an acid condition of the contents, produced by a special bacillus, which prevents other bacilli growing with any readiness. Bacteriological examinations of the vagina and the cervix go to show that there are three zones differing in bacterial contents. The middle zone, narrow in extent, is situated in the cervix uteri, just within the external os. It is usually occupied by a plug of mucus and contains only a few bacteria, all in a more or less debilitated condition. Below is the first zone, including the vagina, where bacteria abound. Above in the cervix and internal os uteri is the third zone, which is free from bacteria. The middle zone is the barrier where natural sterilisation takes place. This condition obtains also in pregnancy, and if in examining a case of labour we pass our fingers up through the cervix to feel the membranes we



must necessarily interfere with or break down this natural safeguard against sepsis and permit the introduction of sepsis into the aseptic zone, and through the ruptured membranes into the hitherto aseptic uterine cavity. The possibility of the entrance of sepsis into the vagina and parturient canal is the greatest disadvantage of vaginal examination.

There are, on the other hand, great advantages in examination by the vagina. Its use in the very early stages of pregnancy is invaluable, combined with abdominal examination, in determining pregnancy itself.

In very early pregnancy, even as early as the third or fourth week, we get a very characteristic condition which has already been referred to before this Society by my colleague, Dr. Burford, as Hegar's sign of early pregnancy. With its help one may be enabled to determine pregnancy with certainty as early as the sixth week, and sometimes earlier. The feeling on bimanual examination, which must be as complete as possible, is that the upper portion of the cervix of the uterus, or the lower portion of the body, is very soft and thin. The lower cervical portion remains more or less its normal size, while above there is a bulging. That bulging is most noticeable to the vaginal finger, which is passed up in front of the cervix along the anterior aspect of the fundus, where there is a sudden bulging. If you find that bulging in a case where one period has been missed, and there are other possibilities of pregnancy, you can hardly err in diagnosing early pregnancy. Of course, it is better to corroborate your diagnosis by reference to clinical signs of pregnancy and the condition of the breasts, but Hegar's sign alone is a very reliable one.

Let me cite one other instance where the double method of examination is indispensable; it is in a case of feigned pregnancy. In this case, of which I show a drawing, there were clinical evidences of pregnancy; it was nearly at full time, thirty-six weeks, but it was discovered by bimanual examination that the uterus was in a normal condition, and that the rest of the abdominal swelling was a phantom tumour.

I recently had an interesting example of feigned preg-



nancy. A lady, on coming to reside near me, told me that she was four months pregnant, that her previous attendant had seen her about the second or third month, and had told her she was pregnant. The time of delivery was fixed from these data and the nurse engaged. About the time arranged I was duly called and arrived at the lying-in chamber. The nurse was there, the patient duly prepared, and the usual layette, &c., warming by the fire. The patient complained of the usual labour pains, which appeared genuine. I proceeded first to palpate the abdomen, but could find nothing corresponding either to a breech or to a vertex, or to any foetal part. The abdomen was merely unusually distended. My diagnosis was corroborated by the vaginal examination. The surprise and disappointment of the patient when the condition was explained to her was only exceeded by my chagrin at having been led to forego in her case on her representations the preliminary abdominal examination during the later months of pregnancy, which I have found so indispensable in giving valuable foreknowledge as to the probable course and character of a confinement.

In conclusion, a good deal more might be said on behalf of the two methods of examination, the abdominal and the vaginal, but there is no doubt that each is complementary to the other. The ideal method is to insist, if possible, upon abdominal palpation in the later months of pregnancy, and certainly as a first procedure when called to conduct a labour. Such a method is in true accord with the best traditions of our art, and to recognise that the employment of every procedure which may be useful in diagnosis, treatment and prognosis, is surely the only true and scientific position.

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## A CASE OF SEVERE PAIN IN THE LEFT LEG FOLLOWING LABOUR.<sup>1</sup>

BY JOHN McLACHLAN, M.A., B.C.L.OXON., M.D., B.Sc.EDIN.,  
F.R.C.S.ENG.

ABOUT a year ago I had a very troublesome confinement case—troublesome, not so much in the confinement itself, but in the pains experienced by the patient afterwards. It was her fifth confinement, but this same trouble showed itself first, though but slightly, in her third, very severely in her fourth, and was apparently to be worse still in her fifth. The troublesome symptom to which I refer was intense and agonising pain in the region of the tibia, or in the tibia itself, beginning a short time after labour. On the first occasion it began from twelve to twenty-four hours after the child was born, and I then thought it was an example of a case quoted by the late H. N. Guernsey (in vol. i. of *Medical Counsellor*, 1879) of after-pains in the shin-bone, for there were exacerbations and remissions occurring as regularly as if they were in the uterine region. For cases like these Dr. Guernsey recommended *carbo veg.* I gave this remedy on the first occasion and the pains soon afterwards disappeared. In the light of subsequent events, however, I am inclined to think that this was an example of a *post hoc* and not a *propter hoc* cure.

At first sight it may seem strange to have after-pains in the shin-bone, but, though strange, it is not impossible. I once had a case of undoubted dysmenorrhœa in the right shoulder-joint—to be sure the joint was a diseased one, and the usual menstrual discharge was absent. When this discharge was re-established there was no more pain in the shoulder-joint.

To return to our case: In her fourth labour, the pains came on in twenty-four hours or so after the child was born, and lasted something like nine days. They were not constant, but occurred four to eight times in the twenty-four

<sup>1</sup> Presented to the Section of Materia Medica and Therapeutics, February 2, 1905.

hours, in agonising paroxysms. During the paroxysm she would toss from side to side of the bed, and the perspiration would roll off her face. I tried many medicines, but I do not think that any of them did much good. We thought that china was the most effective, probably because it was the last to be used, but the case ended, for this time, in natural recovery, not cure.

In her fifth labour the pains began, much to my horror, about twelve hours after labour, but, happily, I was able, as I shall afterwards show, to keep them in check and make her fairly comfortable, if not entirely free from pain.

Now, what was the real nature of this affection? It had nothing in common with, and no relation to, *phlegmasia alba dolens*, nor neuritis due to septic infection, so far as I could make out. Was it due to the bruising of the great sciatic nerve during its intrapelvic course by the child's head (labours were all L. O. A.), and was the left nerve affected because, in this country, the woman usually lies on that side? Had this been the cause, one would have expected that such medicines as *hypericum*, *symphytum*, or *ruta*, would have rendered valuable aid, whereas they one and all failed to help in the slightest degree. The roots of the sacral plexus, as you know, lie upon a cushion of muscle, but the lumbo-sacral cord, arising from the fourth and fifth lumbar nerves, passes over the *bony* pelvic wall at the brim of the true pelvis, where it is exposed to injury by the child's head entering the pelvic inlet. From the lumbo-sacral cord comes the main root of the peroneal nerve, and, clinically, it has been found that paralysis of motion due to traumatism during labour is often a loss of power of the muscles supplied by this nerve. It has been further pointed out by Mills and Hünemann that this peroneal paralysis is usually associated with severe neuritis. In the second attack (fourth confinement) there certainly was marked muscular weakness of the leg for a long time, though I did not particularly investigate what muscles were specially affected. The superior gluteal nerve arises from the posterior part of the lumbo-sacral cord, and may also be involved by the spread of the inflammatory process, especially if of septic origin.

On the other hand, in cases where the injury is due to the forceps, the roots of origin of the internal popliteal, rather than those of the external popliteal (peroneal) nerve are apt to suffer.

The case being so serious, I made an effort to collect all the symptoms I could, no matter how trivial. These symptoms were meagre enough:—

- (1) She could not lie on the affected side, *i.e.*, the left.
- (2) The location and direction of the pain seemed to be along the course of the great sciatic nerve and its main branches, and in the tibia.
- (3) During the attacks of pain there was severe palpitation of the heart.
- (4) During the paroxysms she could not keep still, but tossed from side to side of the bed, beat her hands together, struck her head and face with them, &c.
- (5) The pains were burning in character, and as they were passing off they left burning spots on the shin-bone.
- (6) There was also shooting and tearing down the leg, as if the whole leg, or bits of it, would break off.
- (7) The leg felt expanded, especially the ankle and foot.
- (8) The pains were intermittent; sometimes she would be almost or quite free from pain.
- (9) There was intense exhaustion after the paroxysms.

Remembering her previous confinement and that china then seemed to give relief, we again gave china, but without effect. I called again in the evening, and found she was no better, and after mentally reviewing all the various symptoms I gave her *spigelia*.

This was on a Sunday night, and having but little to do, and feeling in the humour for work, I did what I very rarely do, made a study of the case according to the *numerical method*, using Bönninghausen's Symptom Index as far as it would go, and trying to assess the true value of each medicine under which the symptom appeared. It may be objected that this method is too mechanical, and no doubt it may be so, but it may also be used *with brains*, and in the present case there seemed no other method open to me.

The method I adopted took some five hours of steady, hard work, but during that time I had to read the greater part of two or three books dealing with neuralgia, and referred some hundreds of times to other works on materia medica. I will not weary you with the details of all the medicines passed in review, but only refer to a few points that one may reasonably be expected to keep in one's head for daily use.

(1) Aggravation for lying on the painful side.

Arsen., bell. (in chest cases, as pneumonia and pleurisy), clem., dros., kali. c. (worse at 3 a.m.), kali. i., ign., lyco., nux v., ruta, sep., sil., *spig.*, syph., tell., thuj. Compare—

Pains go to the side lain on, bry., phos. acid, puls.

Aggravation from lying on the left side, lyco., phos., sepia.

Amelioration from lying on the painful side, bry., cup. acet., ign., sulph. acid.

(2) Rapid beating of the heart during the paroxysms of pain, arg. m., crot. h., lach., *spig.* (agitation and anguish of heart during pains).

(3) Crescendo-decrescendo type of pain, chelid., plat., stann., sep., stront. c.

Compare the so-called "sun pains," *i.e.*, pains increasing till 12 noon, and then decreasing, and ceasing about sunset, arg. n., chelid., gels., kali. bi., kalmia, nat. m., stann., *spig.*, verbas.—medicines frequently used in "sick headaches." Compare also—

Aggravation from sunset to sunrise, "prays for daylight," syph.

Aggravation from sunrise to sunset, medorrh.

(4) Pains, agonising—(a heading of little importance)—acon., kalmia.

Drives patient crazy, cham., tereb., thuj.

Extorts cries, mag. ph.

Drives out of bed, arsen., ferr., mag. ph., phyto., puls.

Excruciating, nux vom.

Insupportable, arsen., cham., coff., coloc., lac. c., lach., mag. c.

*Iod.*, cannot rest in any place ; changes place constantly, and is fatigued by so doing.

*Arsen.* has the same restlessness as iodine, but not the fatigue. Motion diminishes the pains of *rhus*, and the patient is better for a while in the new position, though motion continued for too long a period induces a paralysed feeling, which rest again removes. In *puls.* the pains also cause the patient to move about, but he is no easier in the new position. *Caust.* resembles *puls.* in this respect, while *nat. sulph.* resembles *rhus*. In *eupator. perf.* there is constant change of position, though the pains are not worse from repose, and there is no relief from motion.

(5) Aggravation from touch, *acon.*, *adn.*, *arsen.*, *bell.*, *caust.*, *cham.*, *chin.*, *chin. s.*, *clem.*, *coff.*, *coloc.*, *cup. (acet. or met.)*, *kalm.*, *lach.*, *mag. c.*, *mag. ph.*, *nux v.*, *spig.* (sensibility of the whole body to), *stann.*, *tarent.*, *valer.*, *verbas.*, *viscum.*, *verat.*, *zinc.*

Aggravation from the *slightest* touch of parts already the seat of pain, *bell.*, *chin.*, *ign.*, *nux v.*, *phos.*, *stann.*, *staph.* (of spoon or fork on lips).

In *lach.* and *chin.* more especially, while touching softly aggravates, firm pressure relieves. In *sang.* pains disappear on touch, but reappear in another part. In *lach.* the sensitiveness seems to be due rather to an increased irritability of the sensory nerves, contrasting very markedly in this respect with *apis* and *bell.* In some cases we find a great fear of persons coming near to the affected part (lest they touch it), as *anac.*, *arnica* (in gout), *chin.*, *con.*, *ign.*, *lyco.*

(6) The pains were stabbing and darting; *chin.*, *cimi.*, *coloc.*, *gels.*, *graph.*, *hyper.*, *ign.*, *kali bi.*, *kalm.*, *lach.*, *mag. ph.*, *nux v.*, *sang.*, *spig.*, *syph.*, *tereb.*, *thuj.*

(7) Painful spots, burning like fire, *arsen.*, *thuja.* Pain in spots is found under many medicines, but chiefly *agar.*, *calc.*, *carb. v.*, *caust.*, *colchicum*, *fluor.*, *ac.*, *kali bi.*, *kalm.*, *lach.*, *lil. tig.*, *mag. ph.*, *ox. ac.*, *onos.*, *phos.*, *sang.*, *spig.*, *tell.*, *thuja*, *zinc.* In the case of *spig.* and *colch.* there is subsequent *swelling* and soreness of the parts affected, *e.g.*, in facial neuralgia.

(8) Sensation as if thigh would break, *kali iod.* (as if dislocated), *ruta* (as if bone were broken), *valer.* (as if thigh would break on straightening out the limb).

(9) Cannot keep still; must toss about; a great many medicines, but chiefly acon., arg. n., arsen., aur., baptis. (because parts rested or feel sore and bruised; here also, as well as in arnica, the bed feels too hard); bell. (a remarkable *quickness* of motion and sensation); carbo. v. (restless and anxious from 4 p.m. to 6 p.m.); caust. (in rheumatic pains no relief from the motion, *cf.* rhus tox.); coloc., cup., ferr. (slow motion lessens pains, *cf.* rhus); eupator. perf. (restless though pains are not worse by repose, nor are they relieved by the motion); iodine (sits up in bed and throws himself upon it); puls. (must move, even though motion aggravates the pains, nor is he any easier in the new position, but the puls. headache is relieved by *slow* motion in the *open air*); rhus (worse on first moving, better from continued motion, is better for a short time in the new position, yet he must soon move again); silica, sepia. Restless, worse in the evening, carbo. v. (4 to 6 p.m.), lauro., merc., nux v., phos. Tossing in bed, acon., cham., cina, ferrum, merc. Wants to go from one bed to another, arsen., bell., calc., cina, cham., hyos., mezer., rhus t., sep., verat. Restless feet, bell., zinc (fidgety). In bell. the feet are in constant motion, shifting about all the time. In sepia there is restlessness and a fidgety feeling in the legs, with formication in them. In arsen., caust., eupat. perf., ferr., puls., and ruta, there is no relief from motion, and yet the patient must move.

(10) Burning pains, chiefly, arsen., carbo. v., ced., china, coloc., gels., ign., iris, kalmia, lyco., rhus, ruta, sang., *spig.*, stann., thuja, zinc.

Sensation as if burnt, bell., ign., nux. v., plat., puls., sepia, thuja.

(11) Intermittent or periodic pains, arsen., cham., chin., chin. s., coloc., crot. h., gels., graph., ign., lyco., mag. ph., nat. m., nux. v., sang., sep., *spig.*, stann., verbas., verat.

(12) Feeling of expansion or sensation of enlargement, alumina, arg. n. (in convulsions), arsen., bell., carbo. v., chin., plat. (in hæmorrhage), puls., rhus., *spig.*, stann., verat., zinc.

(13) Coverings intolerable, cham., chin., ferr., lyco., plat., puls., *spig.*, verat. (agar., caust., hepar., nux. v., rhus and

sulph., the reverse). Aggravation worse from the pressure (as opposed to the warmth) of the clothes, calc., carbo. v., lach., sep., stann.

(14) Aggravation from straightening out affected limb, calc., carbo. v., chin., lyco., plat., puls., ruta, sep., *spig.*, sulph., thuja, valer. (rhus tox., the reverse).

(15) Tibia affected (a heading of doubtful value), calc., carbo. v., dulc., kali bi. (right), kali i., merc., mezer., zinc.

Pains in bone, kali i., puls., rhod., ruta, sep., *spig.*

The values of the various medicines were then assessed to the best of my ability, though it is quite possible that each of us would have given slightly different values here and there. On adding the "marks" up, the order of merit was the following: *Spig.* 28; arsen., 21; puls., 19; calc., china, 17; carbo. v., lyco., stann., 16; ruta, 15; nux v., 14; bell., thuja, verat., 12.

Now, was *spigelia* the *similimum* or merely a *simile*? In other words, was it *the* one, or was it only one out of several, any one of which might have done just as well?

The relief was no doubt marked and prompt, yet not sufficiently marked to please me, though the patient was quite pleased; and so I did not feel justified in altering the prescription or trying further experiments. She did not have another *severe* attack of pain after beginning the *spigelia*, but the pain did not quite disappear for days, though this caused her but little inconvenience.

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Dr. MURRAY MOORE said he believed those who had practised homœopathy for a long period got certain favourite medicines, perhaps half-a-dozen, and used them like a good carpenter used his tools. It was surprising how many conditions and temperaments could be treated with those few, of which in his experience *spigelia* was one. Had Dr. MacLachlan used Bönninghausen's pocket-book? It was an excellent work, though it was necessary to use it for a year or two before becoming quite familiar with it. There were four distinct classes of type in it. He thought a homœopathic practitioner should not be too pathological in his prescribing. The tendency of the younger men seemed to lean in that direction. Symptomatology should be cultivated. The perfection of homœopathic prescribing would consist in removing



a morbid condition which was palpable, such as a tumour, a pathological state evident to the senses, and also presented symptoms. The perfection of the homœopathic similimum covered both the subjective and the objective symptoms. He thought every man, however busy he might be, should have in his carriage the handbook of Allen or Bönninghausen's pocket-book and use it well.

Dr. DYCE BROWN said the Society was indebted to Dr. MacLachlan, who had carefully given not only the result of his case, but his method of study of the *materia medica*. It was difficult always to find time to pursue this method thoroughly. However, the next best thing to doing it one's self was to hear how it had been done by somebody else, and to learn the result of comparisons.

Dr. H. SPEIRS ALEXANDER said that with regard to Bönninghausen's pocket-book, to the greater number of practitioners it was a sealed book. He did not know how Dr. MacLachlan used it, but would like to mention a great aid to the use of it which might not be known to the majority of those present. It was Guernsey's Bönninghausen, or Guernsey's Index to that work. It consisted of a large number of slips of paper, at the head of each of which was a number, and that number indicated a symptom, which might be a symptom in any part of the body. Under that number were ranged all the medicines which possessed that symptom in their pathogenesis, from aconite down to the last letter of the alphabet, all the medicines which Bönninghausen included in his repertory. Aconite might have figure 1, and belladonna figure 2, the numbers at the side indicating the relative value of each medicine under the system. If there were six symptoms one selected slips corresponding to those six symptoms, and put them side by side. Then, by reading across from left to right, the indicated remedies and the numbers prefixed to each, under those headings, and by adding the totals of the numbers the remedies most clearly indicated could be ascertained and afterwards by referring to the *materia medica* the appropriate one could be selected. He had used that index in difficult cases for some years and had found it very valuable.

Dr. GOLDSBROUGH raised the question as to the cause of the condition described by Dr. MacLachlan. Was it absolutely necessary that it should be either trauma or sepsis? Might the condition not be due to a process connected with involution of the uterus? Why did many patients suffer from after-pains, while others did not? He remembered a case once of after-pain

confined to the perineum. Labour had been quite normal, but there were definite after-pains in an area of two or three inches of perineum. He found the remedy for that symptom was *actea* and that drug relieved the symptom. He thought the question of the tissue involved in the experience of pain was very important in the selection of the remedy. In Dr. MacLachlan's case the tissue was definitely nervous. Why should not the pain in his case be analogous with those obtained not merely from pressure, but from irritation higher up, such as the pain under the shoulder in liver trouble or down the arm from angina pectoris? A consideration of the tissue affected pointed to a certain number of drugs, of which *spigelia* was one. For instance, in neuralgia in the head one often used *spigelia*. He remembered a case which was clearly due to acute throat trouble where the neuralgia was induced by that, and which was promptly relieved by *spigelia*. He would not suggest there was any definite connection between the acuteness of a cause and the symptom, but he thought there might be some definite connection between the use of a remedy and the acute onset of the ailment, of which the use of *spigelia* would be an instance.

Dr. MACLACHLAN, in reply, referred to the pleasure in overcoming an obstacle, and the zest which being baffled gave. He had used Bönninghausen's pocket-book, but it was not extensive enough for this case and did not include the more recent medicines. He also had the index which Dr. Alexander spoke of. *Spigelia* was there, and if all the symptoms one had nowadays were there, it would be most valuable. In his case he did hunt for the cause, and thought it was a case of traumatism of some nerve in the pelvis. He tried *hypericum* and *ruta*, and other medicines, but none were the least use. The temperature was normal throughout.

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## CHLOROFORM AND ALLIED ANÆSTHETICS.<sup>1</sup>

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### I.—HISTORY OF EARLY ATTEMPTS IN ANÆSTHESIA.

PEDANIUS DIOSCORIDES, a Greek physician of the first century of this era, who was noted for his *Materia Medica*, and Pliny, his contemporary, both mention the use of

<sup>1</sup> Presented to the Section of Surgery and Gynæcology, March 2, 1905.

mandrake, the atropa mandragora, as an anæsthetic when taken internally. So does Galen. The two former refer also to the Stone of Memphis, *lapis memphiticus*, which, when pulverised and made into an unguent, and smeared on the part to be operated on, rendered it free from sensation.

In the third century Hoa-tho, a Chinese surgeon, used Indian hemp before operating.

In the thirteenth century Hugo de Lucca, a Tuscan, used an oil, by smelling which, he put his patients to sleep; his assistant, Theodoric, was sceptical.

In 1589 John Baptista Porta, a surgeon of Naples, used an essence made from hyoscyamus, solanum, poppy and belladonna, preserved in a leaden vessel, which was inhaled for the same purpose.

In the time-immemorial practice of Sahamaranya (concremation) in India, the widow, before mounting the pyre, was smeared over with an unguent, which rendered her immune from pain.

#### LATER HISTORY.

In 1774 Priestly discovered oxygen and nitrous oxide. Both were used soon after for medical purposes.

In 1795 Dr. Pearson, of Birmingham, substituted ether for oxygen without anæsthesia.

In 1798 Dr. Beddoes founded the Pneumatic Institute at Clifton. Mr. (after Sir) Humphry Davy was his assistant, and he it was who discovered in the first year of the nineteenth century the anæsthetic effects of nitrous oxide by accident; he suggested this gas might be used for surgical operations, and this was realised fifty years after.

In 1818 Faraday discovered for the first time the anæsthetic effects of ether, and *he* prophesied a future for it; realised thirty years after.

In 1835 Collyer, an American student studying at University College, inhaled ether and became insensible, and it was soon after used in the States in combination with mesmerism for operations.

In 1844 Coulton, an American chemist, exhibited the properties of nitrous oxide. Horace Wells, his pupil, took it at the hands of Coulton, whilst Dr. Riggs extracted a tooth. Wells was much impressed, and started practice himself, but was met by failures, and committed suicide in despair.

Charles Jackson, his pupil, experimented with sulphuric ether, and communicated his success to W. T. Morton, who started practice.

In 1846 ether was first used in important surgical operations by Dr. Warren, at the Massachusetts General Hospital. On December 19 of the same year, 1846, James Robinson, a dentist in Gower Street, London, first used it in practice in England. On December 21, three days later, hearing of Robinson's success, Robert Liston employed it in University College Hospital for general surgery.

In 1847 it was used generally, and Dr. John Snow was its chief apostle. He it was who carefully investigated the subject, and published his results the same year in a small work, "On the Inhalation of the Vapour of Ether in Surgical Operations."

Immediately on the heels of ether comes chloroform. Discovered independently by Loubeiran in 1831, and Liebig in 1832, it was investigated by Dumas in 1835, and was recommended to Simpson, of Edinburgh, by a Dr. Gregory (who does not seem to have tried it himself) as a substitute for ether. At this time Simpson was using ether in his midwifery practice, but he was so pleased with chloroform that he discarded ether in its favour, and published a paper on November 10, 1847, which was read before the Edinburgh Medico-Chirurgical Society, called "Notice of a New Anæsthetic Agent as a Substitute for Ether in Surgery and Midwifery," after which chloroform began to supplant ether, but an unfortunate crop of deaths in the south, viz., London and district, caused a rally to ether; whilst in Scotland, where surgeons had been more fortunate, chloroform held the field. It was Snow who again came to the rescue and saved chloroform from its evil reputation. By a most exhaustive investigation, which was embodied in a book

entitled "Chloroform and Other Anæsthetics," he compiled practically all that is worth knowing on the subject, and all later work is either a repetition or elaboration of the same. Extraordinary as it is, this book has gone out of publication, but all workers in anæsthesia look up to Snow as the great teacher on anæsthetics.

The mantle of Snow fell on Mr. J. T. Clover, whose great mechanical genius enabled him to put on the market the embodiment of Snow's teaching, but his name will always be more associated with ether than chloroform. Chloroform soon began to be used in combination with ether in various proportions; there was thus the A.C.E. combination and C.E. mixture.

Snow introduced also amylene, a substance discovered by M. Balard, of Paris, in 1844, and made from amylic alcohol by distilling with chloride of zinc. It is composed of C. and H., and bears the same relation to amylic alcohol that olefiant gas or ethylene bears to common alcohol. This preparation never became popular, but is used in Germany in dental practice as pental.

Ethyl bromide and ethylidene dichloride,  $C_2H_4Cl_2$ , or monochlorinated chloride of ethyl, which is the same as the old Dutch liquid, was first used as an anæsthetic by Snow, and ethyl chloride,  $C_2H_5Cl$ , was not used for years after.

Many other preparations have anæsthetic effects, such as isobutyl chloride, methyl chloride, tetrachloride of carbon, bichloride of methylene, acetate of ethyl, chloral, &c., but have not come into general use.

*Chloroform* has become a household word, and great interest attaches to it in the lay as well as professional mind. Its formula is  $CHCl_3$ . It "is a clear, colourless liquid, having a hot and intensely sweet taste, is not inflammable, but when paper moistened with it is introduced into a flame of a candle it is destroyed, with the evolution of smoke and chlorine gas. It is just half as heavy again as distilled water."<sup>1</sup> Its specific gravity is 1.500 at 60° F., therefore, one ounce by measure weighs one and a half ounces by weight. The vapour of chloroform is more than four times

<sup>1</sup> Snow on "Chloroform."

as heavy as atmospheric air, and has a specific gravity of 4·2 at 60° F., but it only exists under ordinary conditions by a free admixture of air. It is calculated that 1 cc. of vapour weighs at 60° F. 4 mg., heavier than the same quantity of air, and, as I shall show afterwards, an easy estimation of percentage is calculated on this knowledge. It can exist only in a pure state at a temperature of 140° and upwards, or when atmospheric pressure is removed by air pump.

The following tables from Snow's book represent the absorptive power of air.

I.—The following table shows the result of experiments made by him to determine the quantity of vapour of chloroform that 100 cubic inches of air will take up and retain in solution at various temperatures :—

Temperature, Fahrenheit.		Cubic Inches.	Temperature, Fahrenheit.		Cubic Inches.
40°	...	7	70°	...	24
45°	...	8	75°	...	29
50°	...	9	80°	...	36
55°	...	11	85°	...	44
60°	...	14	90°	...	55
65°	...	19			

II.—The following table shows the quantity of vapour in 100 cubic inches of the saturated mixture of vapour and air at different temperatures :—

Temperature, Fahrenheit.				Air.		Vapour.	
40°	...	94	...	6			
45°	...	93	...	7			
50°	...	92	...	8			
55°	...	90	...	10			
60°	...	88	...	12			
65°	...	85	...	15			

Temperature, Fahrenheit.				Air.		Vapour.	
70°	...	81	...	19			
75°	...	78	...	22			
80°	...	74	...	26			
85°	...	70	...	30			
90°	...	65	...	35			

This principle is of great practical importance, as Snow points out, especially in relation to the open method of administration of chloroform, for if chloroform be administered on a handkerchief, and in such a way that the patient is inhaling it, half saturated, a not impossible condition, if the temperature happens to be 50°, the air will contain 4 per cent., but if at 70° it will contain 9·4 per cent., an absolutely lethal concentration. One must always remember

that a considerable amount of caloric becomes latent during the evaporation of chloroform, and the temperature of vapour and air are greatly reduced. This is very important in comparing the open method, as per Skinner's inhaler or a towel, and the so-called closed method, as Junker's, in which latter case the amount of chloroform vapour depends on the amount of air forced through the chloroform fluid, and in which case the greater the evaporation the greater the reduction of temperature of the fluid, so that if the temperature of the room be great, the increased evaporation at first is compensated for by the necessary reduction of temperature, a condition not so much pertaining in the open method with the impact of a constant free flow of air at a high temperature.

Snow was the first to categorise the symptoms produced by chloroform into "degrees" as he had previously arranged those of ether, and, curiously enough, they so closely resemble one another that they can be described together.

There are, according to this authority, five degrees of narcotism (a term Snow prefers to anæsthesia, which means really "privation of feeling," whilst narcotism refers to "the entire effects of these agents on the nervous system"). Only three degrees, however, are necessary for surgical operations, the fourth being a warning and the fifth precedes death. Shortly, the five degrees may be described as follows :—

The *first degree* includes all the effects of chloroform that take place whilst consciousness persists, and constitutes all that the patient remembers afterwards. In careful administration these effects are generally agreeable; they are principally dizziness, singing in the ears, and tingling in the limbs. They are peculiar, and have to be experienced to be understood. These recur as the patient regains consciousness, and that is why, after a long operation, the patient wonders that it is all over. He takes up the threads of consciousness where he lay them down at the commencement.

The *second degree* is marked by a confusion of consciousness, sleepiness, but with voluntary movements of eyes and limbs. The patient may laugh, talk, or sing. This is the



stage in which dreams occur. There is semi-voluntary resistance. This degree of narcotism is all that is necessary for the less painful operations and obstetrical practice.

In the *third degree* there is no longer any voluntary movement: pupils are not voluntarily fixed on any object, but generally inclined upwards. In the early stage of this degree there is generally rigidity of muscles, not voluntary, but sufficiently unpleasant to the surgeon to call forth a protest. Sometimes these movements take the form of spasms of an epileptiform character, and often, as I have noticed, of a cataleptiform nature; the patient mutters incongruously, but noises made are generally inarticulate and unintelligible. This is followed by relaxation of the muscles in the later part of the third degree.

Regarding the three eye reflexes, the orbicular, the sclerotic, and the corneal, it is not necessary to abolish either the sclerotic or corneal, but, especially at the early part of the operation, it is as well to abolish the orbicular reflex, which is a good indication of the fitness of the patient to receive the skin incision, very often the most painful part of the whole operation, and that which tests the anæsthesia most. For painful operations perhaps the ideal state of narcotism is where the orbicular and sclerotic reflexes are abolished and the cornea retained. There are exceptions, but this is a good working rule.

The *fourth degree* is marked by stertorous breathing, dilated pupils, ultrarelated muscles, and absolute insensibility. This may be necessary for very special operations, such as reducing dislocations, and in certain tumours, but, as a rule, is a condition to be avoided. Stertor I consider, except in special cases, undesirable, and even with ether unnecessary.

The *fifth degree* is only intentionally produced on animals; the breathing entirely ceases, the heart continues to pulsate for a time, till its action is arrested by the cessation of respiration.

The pupils often dilate in the second degree, but at this period are always mobile. As the patient acquires the third degree these contract. When in profound anæsthesia they



dilate again, this time they are immobile, and this is a warning we should never wish or require. The respirations should be regular, in other words, automatic; they are always quicker than normal, 54 per minute not being unusually high; when it becomes irregular it may be due to returning second degree, in which case it will be necessary to give more of the anæsthetic, or it may be due to too large a quantity in the system, in which case administration must be stopped.

The action of chloroform on the body should be divided into its effects on: (1) respiration; (2) heart and circulation; (3) the brain (loss of consciousness); (4) the nervous system (loss of sensibility).

In studying the lung capacity the various acts of respiration are divided into tidal, reserve, residual, and complemental.

{ 2000 C.C. 120 CUB. IN.	COMPLEMENTAL	} VITAL CAPACITY
{ 500 CC. 30 CUB. IN.	TIDAL	
{ 1500 C.C. 100 CUB. IN.	RESERVE	
{ 1500 C.C. 100 CUB. IN.	RESIDUAL	} CAPACITY OF EQUILIBRIUM

The vital capacity is the combination of complemental, tidal and reserve, or the amount of air which the person can inspire with the deepest inspiration, after making the most forcible expiration, and represents from 3,000 to 4,000 cc. The capacity of equilibrium is the quantity which remains in the chest after ordinary expiration, and amounts to 3,000 cc.

Now let us examine what happens. In chloroform anæsthesia, chloroform-laden air passing into the lungs (the latter being a *cul-de-sac*) meets with the resistance of the

reserve and residual air. Some is returned unchanged in the next expiration, but the diffusion is so great that this is a small quantity, and when given in proper percentage is, in the early stages, not detectable by the nose. It is only when the blood has become changed that it begins to show its presence in the expired air sufficiently to be detected by the sense of smell. It is calculated that 18 minims in the blood is necessary to produce surgical anæsthesia, requiring perhaps a presentation of 36 minims. When chloroformed air gets into the lungs it is further diluted by the air already there. Having reached the vesicles it is immediately absorbed by the blood.

The air in the lungs being of a higher temperature than that inspired, makes it capable of quicker diffusion, and containing higher percentage. This at first is a safeguard by dilution, but afterwards a danger by accumulation, which tends to reach saturation point at the temperature of the body—a very lethal condition.

Up to a certain point this is prevented by the further diffusion of the chloroform in the direction of the blood, with which the pulmonary area is bathed.

### BLOOD.

Now blood has a great affinity for chloroform. Waller has shown by an interesting series of experiments that blood absorbs much more chloroform than water or saline, and in treatment by a Geryks air-pump less in proportion is recovered from blood than the saline (*i.e.*, blood absorbs quickly and retains long). It is probable that protoplasm is the great solvent, and it has been suggested that its absorption is due to the contained lipoid ingredients of protoplasm (*viz.*, lecithin and cholesterin).

We should not lose sight of the fact in this connection (1) that the surface area of the pulmonary circulation has the same relation to the heart as a wedge has to its apex; chloroformed blood is being constantly collected from both lungs and discharged into the left auricle; (2) the heart itself is nourished by blood-vessels that are the first offshoots

from the aorta, viz., the coronary, and, in consequence, the heart receives the first shock of a surcharged portion of blood; (3) the next direct current of blood is to the brain.

Snow calculated that the relation of the blood absorption to the air absorption was definite and fixed as follows: As the proportion of vapour in the air breathed is to the saturation point at blood temperature, so is the proportion absorbed by the blood to that the blood can dissolve. Blood will dissolve its own volume of  $\text{CHCl}_3$  vapour.

V. in A. : S. V. in air :: V. in b. : S. V. in b.

To work a case out, Snow found that in one case 1 grain of chloroform to 100 cubic inches was sufficient to induce the second degree of narcotism.

Now 1 grain of chloroform develops  $\cdot 767$  of a cubic inch of vapour (12.5 cc.) at  $60^\circ \text{F.}$ , and its specific gravity is 4.2; and, although when it enters the lungs it expands, it only does so in the same degree that the inspired air does.

But air, when saturated at  $100^\circ \text{F.}$ , contains 43.3 cubic inches in the 100.

$\cdot 767 : 43.3 :: \cdot 0177 : 1.$

Therefore, if the point of complete saturation be considered as unity,  $\cdot 0177$  will represent the degree of saturation of the air from which the vapour is immediately absorbed into the blood, and, therefore, the degree of saturation of the blood itself.

#### TOXIC ACTION OF CHLOROFORM.

The next question is one of great importance, viz., the cause and prevention of deaths from this substance.

In order to deal with this question, I must refer you to a series of experiments of a humane character conducted by Snow on animals of various sizes and sorts. This series consists of twenty-two experiments on nine guinea-pigs, six mice, six cats, three frogs, one chaffinch, and consists of observations on the effects on these animals subjected to various percentages of chloroform and air. The results may be shortly summarised thus:—

*The third, fourth and fifth experiments demonstrate that*

1 gr. in each 100 cubic inches (.69 per cent.) is sufficient to induce the second degree of narcotism, alike on a guinea-pig, cat and a white mouse.

*Experiments 9 to 12 inclusive*, in which 2 grs. of  $\text{CHCl}_3$  to each 100 cubic inches (1.3 per cent.) cause a very complete insensibility corresponding with the fourth degree of narcotism, with a degree of saturation of the blood of .0354, or  $\frac{1}{28}$  alike in a guinea-pig, a cat and two white mice.

*Experiments 6, 7 and 8* demonstrate the effect of between 1 and 2 grs. of  $\text{CHCl}_3$  in each 100 cubic inches of air on guinea-pigs. In experiment 6, concentration was 1 in 115 (or .86 per cent.). In experiment 7, 1 in 96 (or 1.04 per cent.). In experiment 8, 1 in 82 (or 1.2 per cent.). In each case the guinea-pig was safely anæsthetised in a state of narcotism corresponding with what is required for surgical operations, and all quickly recovered on being withdrawn from the jar. In these three cases the temperature was taken before and after the experiment, and in all there was a fall from  $100^\circ \text{F.}$  to  $96^\circ$  or  $97^\circ$ . (I may say in passing that similar observations made by myself on the human subject before and after operation shows a similar dip.)

*Experiments 13 and 18* show that quantities of chloroform exceeding 2 grs. to the 100 cubic inches (in experiment 13 the proportion is 1 in 64.2, or 1.55 per cent., and in experiment 18, 1 in 38.5, or 2.6 per cent.) have a tendency to embarrass and arrest respiration if continued. In this respect he says: "I have not yet been able to determine satisfactorily the exact proportion of chloroform which requires to be absorbed to arrest the respiration of animals of warm blood. I believe there is a definite proportion which has this effect."

The next series of experiments are with a much more concentrated mixture of chloroform and air.

*In experiment 23* a cat was subjected to what corresponded with 4 per cent. mixture of chloroform and air; the breathing was arrested by the influence of the chloroform on the nervous centres, but the action of the heart continued, and

was subsequently nearly arrested secondarily to the arrest of respiration, but although in this case the respiration had ceased and the heart-beats could not be distinguished by the stethoscope, both recovered by taking the cat out and exposing it to fresh air.

*In experiment 24* a cat was exposed to the same conditions, with the same sequence of events, failure of respiration, followed by a rapid weak pulse, which ultimately ceased. In this case the cat was *not* immediately withdrawn, and died in consequence. It was questionable here whether the heart did not fail before or at the same time as the respiration.

*Experiment 25* was most important. A cat made insensible by a 4 per cent. mixture was taken out, and after awhile its nose was placed into a metal inhaler lined with bibulous paper and containing chloroform surrounded with water at 110° F. The stethoscope was kept applied to the chest whilst the chloroform was inhaled. "After four or five inspirations the heart suddenly ceased to beat, the breathing still going on." After two or three convulsive respirations the breathing ceased.

As regards the heart: experiments were conducted by Dr. R. M. Glover in 1842, before  $\text{CHCl}_3$  was used as an anæsthetic. In animals that were killed by injecting it into the jugular vein the irritability of the heart was found to be destroyed, whilst in others, where it was injected into arteries, stomach, and peritoneum, the irritability was retained. Snow arrested the action of the heart remaining in animals which were opened immediately after death by blowing the vapour of chloroform on it, and the motion of the heart of *frogs* can be arrested by an amount of chloroform somewhat greater than suffices to suspend the respiration. The action of the heart of these animals can be suspended by the absorption of the vapour through their skin.

In this connection experiments conducted by Prof. C. S. Sherrington and Miss S. C. M. Lowton with chloroform on excised hearts of mammals kept alive by perfusing the blood-vessels with warm nutrient solutions may be alluded to.

When the pure nutrient was substituted for one charged with chloroform, the amplitude of the heart was diminished without altering its rate; the amount of diminution was proportionate, within limits, to the concentration of the chloroform. This was more marked in saline solutions, when the depressant action was shown even in a dilution of 1 part in 150,000 of the saline solution. There was, after a point, slight immunity from depression, but this was not permanent. On returning to the chloroform-free fluid the heart regained its irritability and power.

The reason that chloroform acts more powerfully in salt solution than in blood (although this is not the explanation given by Sherrington and Lowton) is that pointed out by Waller, that blood has more affinity for  $\text{CHCl}_3$  than has the saline; so the  $\text{CHCl}_3$  in the latter case would be more readily absorbed by the heart tissue, and so produce its baneful effect.

Having thus reviewed the experimental effects of chloroform, we can draw our own conclusions, and, for my own part, they must be the same as those drawn by Snow, especially when placed side by side with the enquiry from *post mortems* on persons who have died under its influence. Almost without exception the state of the heart showed either a turgescence of the cavities of the heart—at any rate, the right side, with the cavities in a state of diastole, or, if partly empty, evidence of a *post-mortem* turgescence. This is a condition quite contradictory to the state in ordinary syncope, where an empty heart is the case. Snow makes a distinction between the ordinary or anæmic syncope and what he calls “cardiac syncope.” In the ordinary syncope the heart fails from lack of sufficient fluid, to contract upon which would give the necessary stimulus to the next systole. In non-fatal cases relief and restoration of the normal conditions immediately follow the assumption of the horizontal posture or the position of declined head between the knees, when a fresh flow of blood from the distended veins by gravity into the heart gives it the necessary stimulus to contract again.

In the case of fatal chloroform narcosis it is the presence

of blood and not its absence, surcharged as it is with the drug, that causes death by paralysing the heart. This must be the real cause of death in the great majority of these fatalities, the exception, a most improbable one, being where chloroform of non-lethal concentration is persisted in unduly, and in which the respiration fails first. In the former case any one is liable to this accident who uses a method of delivery in which the percentage of  $\text{CHCl}_3$  is unknown; in the latter, fatality in competent hands is almost impossible. In this respect Prof. Waller has shown that even 1·5 per cent. is sufficient to embarrass and arrest the respiration if persisted in after the stage of surgical anæsthesia is accomplished. But, presuming the anæsthetist is not a fool or criminal, he gets sufficient warning to desist and restore the patient before it is too late.

To summarise, then :—

(1) Chloroform is a chemical compound composed of carbon, hydrogen, and chlorine, and is a trichlormethane, or dichlorinated chloride of methyl, or perchloride of formyl.

(2) It has certain definite properties, and always behaves in a definite manner.

(3) It has a certain prescribed manner of absorption by atmosphere, subject to temperature.

(4) Being taken in the form of vapour into the lungs, it is absorbed by the blood and diffuses through the circulation.

(5) It seems to have no definite injurious influence on the blood, but affects the assimilative processes markedly.

(6) It at an early stage affects the higher cerebral centres, and in this result simulates alcohol, which attacks the various centres in regular rotation, the intelligent and volitional centres, before the co-ordinating and reflex and the reflex before the deep vital.

(7) Percentages of  $\text{CHCl}_3$  and air up to 1·5 per cent. and 2 per cent. are safe, and all that are necessary to induce and continue the anæsthesia, but even these are dangerous if continued.

(8) Four per cent. and 5 per cent. are not lethal to the heart, but soon embarrass the respiration.

(9) Any percentages over these are dangerous, and likely to lead to sudden paresis of the heart and death.

(10) Nine per cent. or 10 per cent. will be almost sure to cause death—*i.e.*, that the inspiration of even a small quantity of mixture of this concentration would be likely to produce death, and in such a case the heart would fail first, and the respiration probably continue for a while.

(11) Deaths, with very few exceptions, are due to the toxic influence of chloroform itself on the heart, and not to any previous imperfection of the heart. Patients with heart disease even in advanced stages take chloroform, as a rule, better than strong persons with sound hearts. I should think that in such cases chloroform is a protection rather than otherwise.

The decision at a coroner's court of syncope from previous heart disease is unjustifiable, and should always be (with the proverbial exception) syncope from an overdose.

Now there have been in England on an average (for the last few years) eighty-five cases of published deaths from chloroform per year, which perhaps does not represent half that take place in the British Isles. Why is this? It is due to want of definite knowledge of the causes of death and the danger of certain methods! The method most dangerous is the open, by towel, lint, or Skinner's inhaler. Now, with regard to this latter point, Mr. Legge Symes and Professor Waller experimented with a Skinner's mask, and found that air mixed with vapour drawn from beneath a Skinner's mask by means of a mechanical aspirator (in this case a bellows worked by winch and crank) so arranged that amplitudes ranging from 300 and 500 to 800 cc. were obtained, and with a frequency varying from 10 to 30 per minute. The conclusions, which as regards the Skinner's inhaler are important, are best told in Mr. Legge Symes own words :—

“For a given quantity of chloroform used, greater amplitude led to lower concentration. The effect of varying amplitude is, however, less marked than that of varying frequency.

“From these experiments it appears that at ordinary room temperatures, with moderate and approximately equal quantities of chloroform, the Skinner mask yielded vapour



of fairly uniform concentration between the desirable limits of 1 and 2 per cent., but reaching as high as 3 or 4 per cent. when the chloroform was copiously applied. The more open of the two fabrics employed gave vapour of higher and, with douches, less uniformly sustained concentration than the closer one. Aspirations of lower frequency and smaller volume led to greater concentration. Comparison of the drop and douche methods showed that a desired concentration is as certainly attained and more uniformly sustained by the former than by the latter.

“It is obviously not legitimate to assume that a given quantity of chloroform, whether by drop or douche, would necessarily yield to the human subject vapour of concentration identical with that found above, even if respiration tallied in depth and frequency with the aspiration employed.

“It is, however, reasonable to conclude that changes in respiration will produce variations in concentration in the same sense as similar variations in physical aspirations, and to emphasise the caution that fall in frequency and depth of respiration may lead to inhalation of dangerously concentrated vapour, even when the amount of chloroform used is apparently not excessive.”

It would, perhaps, be appropriate here to give you the method employed at the Imperial Institute by Prof. Waller for estimating the percentage. This method is by means of glass bulbs called densimetres with a capacity of 250 cc., and founded on the fact that 1 cc. of chloroform vapour weighs 4 mg. more than the same quantity of air at 60° C. Therefore 2.5 cc. will weigh 10 mg. Given a densimetre containing a mixture of air and chloroform which showed an increment of 10 mg., this would indicate 2.5 cc. of vapour, which in a 250 cc. bulb would represent 1 per cent., 22 would represent 2.2, and so on.

Now to quote a common and possible case. A patient is being anæsthetised in a hot operating room with a Skinner, well supplied with chloroform and declared by the anæsthetist as ready for the initial incision. It may be that there is a lack of ordinary reflexes; the surgeon inserts his knife, the patient kicks. There is an annihilation of con-

sciousness by the action on the brain, but not an annihilation of sensibility. The surgeon protests, and the anæsthetist "pushes the chloroform," that is, more is put on, and the inhaler is placed nearer the mouth. The patient's respiration is stimulated, after, perhaps, shallow breathing, and at the critical moment takes a deep breath with chloroform added, and, the inhaler pressed on to the nose and mouth, air is excluded, and the patient takes a lethal dose, the heart is paralysed, and the patient dies beyond resuscitation. I believe we should find that was the common story.

The latest investigators are all satisfied that the correct procedure to aim at is an apparatus capable of giving a known or relatively known percentage.

I wish to introduce to your notice three different forms of apparatus having the object of supplying to a patient a relatively known percentage of chloroform; they are:—

- (1) Krohne and Sesemann's inhaler.
- (2) Professor Waller's inhaler.
- (3) Harcourt's inhaler.

Here is Krohne's inhaler, which consists of a graduated bottle containing the chloroform, with a double tube leading into it so arranged that a draft of air is sent, by means of a graduated hand-bellows, down the central tube, which, in passing through the chloroform, displaces a quantity of vapour always proportional to the quantity of air driven through, qualified by the temperature of the air, and a mouth-piece to receive it and mix it freely with air before inspiration.

Here is Waller's apparatus, which consists of a metal receiver for the chloroform, with three wicks dipping into it (as in an ordinary lamp). The wicks are covered with a bell glass closely applied to the receiver and so arranged that there is an air inlet or way, and an outlet for vapour and air mixed. The inlet receives pure air, forced in by means of a foot-bellows, the aim being to supply a constant stream of air at as regular a pressure as possible; the percentage of chloroform is controlled by the height of the wicks (*i.e.*, by the surface of the chloroform-laden wick exposed to the draft of air). The mixture of air and chloroform is presented to the patient by means of a face-piece.

Harcourt's inhaler is worked on the principle that a draft of air allowed to blow on the surface of chloroform takes up the vapour so displaced; this, by a system of valves, mixes with more or less air by a graduated lever, and so the percentage is controlled.

I ought to mention Dubois' pump, which, perhaps, is the most perfect of all, but is very expensive and is liable to get disarranged.

The one I am most conversant with is Krohne and Sese-mann's, with which I am much pleased. I now show you the report on thirty consecutive cases in which this apparatus was used by me. The principle of the apparatus is described above; the calculations are made in the following way. The results, of course, are only relative.

The tidal air is calculated in "Waller's Physiology" to be  $\frac{1}{2}$  litre or 500 cc. (30 cubic inches).

The normal respirations per minute are  $16 \pm 4$  (*i.e.*, 12 to 20 respirations per minute); 1 minim of chloroform yields 17 cc. of vapour, therefore, 1 minim of chloroform given per minute = 17 cc. in relation to 6 or 10 litres (6,000 cc. or 10,000 cc. of air with an average of 8 litres = 21 per cent.). On this basis are calculated the following cases:—

*Case 1.*—A. U., aged 50, F. (female). Operation, abdominal section, large fibromyoma of broad ligament removed, patient blind with double cataract, heart very weak. Krohne used throughout. Surgical anæsthesia induced in five minutes. Time taken in anæsthesia 2 hours 25 minutes; the amount used  $\text{ʒxss}$ .

During anæsthesia slight lividity at early part of the operation, probably due to the posture (Trendelenburg's), this soon disappeared. No struggle, no flow of saliva, no alteration in pulse throughout. One-sixtieth of a grain of strychnine given at request of surgeon at close of operation as matter of course, but not at my wish. No stertor throughout, the cornea reflex persisted throughout. *After-effect* excellent, slight vomit twice, but not distressing. Average percentage .84.

*Case 2.*—M. B., aged 58, F. Cystoscopic examination. Heart disease, post-systolic murmur aortic. Urethra dilated, the trigone scraped for malignant ulcer. Time taken 38 minutes, including induction of anæsthesia. Amount taken  $\text{ʒiiiiss}$ . Time taken to induce anæsthesia 5 minutes. *Course of anæsthesia* normal, no

adverse symptoms, breathing regular. No vomiting, no saliva flow, no stertor. Cornea reflex present throughout. After-effects—no vomit, consciousness quickly regained. Average percentage 1·20.

*Case 3.*—R. T., aged 36, F. Operation, removing hæmorrhoids. Patient nervous, and slight excitement in going off, but no struggle. Time taken 37 minutes. Amount of  $\text{CHCl}_3$   $\text{ziv}$ . Time of induction 7 minutes. Patient very robust.

*During anæsthesia* no untoward symptoms, no vomit, no flow of mucus, no lividity. Cornea reflex present throughout.

*After anæsthesia* no vomiting. Average percentage 1·36.

*Case 4.*—E. H., aged 35, F. Patient very nervous. Anæsthesia induced by 4 cc. kelene. Operation, curetting uterus. Colpotomy, enucleation of fibroid from fundus. No bad symptoms. Time taken 70 minutes. Amount given  $\text{zv}$ . Average percentage ·84.

*Case 5.*—W. J. S., aged 56, M. (male). Anæsthesia induced with 4 cc. of kelene. Man stout, went under easily, pupils did not alter. Sensitive conjunctiva throughout. Average percentage 1·05.

*Case 6.*—K. S., aged 15, F. Mastoid operation. Time taken 55 minutes. Amount of  $\text{CHCl}_3$  used  $\text{ziv}$ . No untoward symptoms, patient composed as if asleep throughout. No stertor, conjunctiva sensitive throughout, very slight vomiting after. Average percentage ·94.

*Case 7.*—D. G., aged 57, F. Operation, excision of parotid tumour. Albumin in urine, organic lesion of heart. Four cc. of kelene at initiation of anæsthesia, slight spasmodic movements. Time taken 23 minutes. Amount of  $\text{CHCl}_3$   $\text{ziiss}$ . Peaceful throughout, conjunctiva reflex present throughout, became conscious and spoke to me before leaving table. Five minutes for induction. *After condition*—no sickness. Average percentage 1·36.

*Case 8.*—C. B., aged 57, F. Operation, colotomy. Four cc. kelene for inducing anæsthesia. Induction 5 minutes. Time of operation 17 minutes. Amount of  $\text{CHCl}_3$   $\text{zii}$ . Average percentage 1·47. *After-effect*—no sickness.

*Case 9.*—H. M., aged 69, F. Operation, colotomy. Kelene 4 cc. for induction, no bad symptoms. Time taken 18 minutes. Conscious before leaving table. *After-effects*—No sickness for hours, then due to condition. Average percentage 1·36.

*Case 10.*—A. E., aged 5. Operation, excision of hip. Child very frightened before induction at very early period. Respiration ceased, pulse feeble, less than 20 minims given up to this. I heard at a previous operation the same alarming symptoms occurred. Strychnine given, recovered easily and rest of the

operation normal. Time taken 30 minutes. Amount of  $\text{CHCl}_3$  3iiss. No after-sickness. Average percentage .63.

*Case 11.*—L. B., aged 36, F. Operation, oöphorectomy. Patient had a temperature. Scoliosis and kyphosis were present. No bad symptoms. Respiration and circulation regular throughout. Time taken 65 minutes. Amount of  $\text{CHCl}_3$  3iv. Very satisfactory. Average percentage .78.

*Case 12.*—A. U., aged 50, F. Same patient as No. 1. Fixing tube per vagina. Time taken 21 minutes. Amount of  $\text{CHCl}_3$  3ii. No adverse symptoms. Average percentage 1.20.

*Case 13.*—H. W., aged 31, M. Operation, excision of congen. cyst of eyebrow.  $\text{CHCl}_3$  given throughout. Time 33 minutes. Amount of  $\text{CHCl}_3$  3ii. No bad symptoms. Average percentage .78.

*Case 14.*—M. A. P., aged 48, F. Operation, removing painful nerve bulb from stump. Patient very nervous, did not go under well; 5 minutes to induce anæsthesia. Time taken 25 minutes. Amount of  $\text{CHCl}_3$  3ii. Average percentage 1.05.

*Case 15.*—S. W., aged 15, M. Operation, cervical adenectomy. Time taken 65 minutes. Was sick during anæsthesia (tuberculous patients are more readily so). No other symptoms. Amount of  $\text{CHCl}_3$  3vss. Average percentage 1.05.

*Case 16.*—A. F., aged 50, F. Operation, removing sequest. from frontal sinus. Time taken 25 minutes. Amount of  $\text{CHCl}_3$  3ii. No bad symptoms. Average percentage 1.05.

*Case 17.*—E. S., aged 43, F. Operation, hysterectomy. This patient showed remarkable tendency to lose eye reflexes, and on regaining them came out of anæsthesia. No bad symptoms. Time taken 1 hour 50 minutes. Amount of  $\text{CHCl}_3$  3vii. Average percentage .84.

*Case 18.*—E. S., aged 37, F. Operation, amputation of breast. Four cc. of kylene used for initiation. Bruit with first sound of heart. Slight albuminuria. Time of anæsthesia 83 minutes. Amount of  $\text{CHCl}_3$  3vss. Average percentage .84.

*Case 19.*—A. H., aged 41, F. Operation, curetting. No symptoms to alarm. Time taken 38 minutes. Amount of  $\text{CHCl}_3$  3iiss. Weight of this patient, 7st. 8lb. Average percentage .84.

*Case 20.*—E. F., aged 7, M. Operation, mastoid. Time taken 60 minutes. Amount of  $\text{CHCl}_3$  3ii. Very easily kept under. Average percentage .42.

*Case 21.*—L. C., aged 39, F. Operation, appendectomy. Normal anæsthesia. Time taken 60 minutes. No stertor, no

sickness, no flow of saliva. Amount of  $\text{CHCl}_3$   $\text{ziiiiss}$ . Average percentage  $\cdot 73$ .

*Case 22.*—W. M., aged 55, M. Operation, dilating urethra. Time taken 15 minutes. Amount of  $\text{CHCl}_3$   $\text{zi}$ . Average percentage  $\cdot 84$ .

*Case 23.*—M. U., aged 22, F. Operation, cervical adenectomy. Time taken 40 minutes. Amount of  $\text{CHCl}_3$   $\text{zii}$ . No complications. Average percentage  $\cdot 63$ .

*Case 24.*—R. B., aged 45, F. Operation, mastoid (Schwartz's). Time taken 90 minutes. Amount of  $\text{CHCl}_3$   $\text{zviss}$ . No complications. Average percentage  $\cdot 84$ .

*Case 25.*—F. W., aged 22, F. Operation, mastoid section. Time taken 60 minutes. Amount of  $\text{CHCl}_3$   $\text{ziiiiss}$ . No complications. Average percentage  $\cdot 73$ .

*Case 26.*—K. D., aged 44, F. Operation, abdominal myomectomy. Time taken 1 hour 45 minutes. Amount of  $\text{CHCl}_3$   $\text{zviss}$ . Shallow breathing at commencement, therefore initial anæsthesia was prolonged, and moved much in first incision. Suffered with asthma, bile in urine. No complications. Average percentage  $\cdot 77$ .

*Case 27.*—M. M., aged 58, F. Operation, hæmorrhoids (excision) and removal of polypus (anal). Shallow respiration at commencement. No complications. Slight vomiting after quick restoration of consciousness. Time taken 27 minutes. Amount  $\text{zii}$ . Average percentage  $\cdot 92$ .

*Case 28.*—L. E., aged 34, F. Operation, curetting. Time taken 35 minutes. No complications. Amount of  $\text{CHCl}_3$   $\text{ziii}$ . Average percentage  $1\cdot 05$ .

*Case 29.*—H. S., aged 34, F. Operation, abdominal section. Time taken 1 hour 30 minutes. No complications. Amount of  $\text{CHCl}_3$   $\text{ziv}$ . Average percentage  $\cdot 63$ .

*Case 30.*—M. P., aged 64, F. Operation, colporrhaphy, trachelorrhaphy and abdominal fixation. Time taken 1 hour minutes. No complications. Amount of  $\text{CHCl}_3$   $\text{zvi}$ . Average 25 percentage  $\cdot 84$ .

I have purposely avoided repetition of negative symptoms in the latter cases. In summing up I recommend this apparatus for the following reasons:—

(1) It is a pleasant method of giving an anæsthetic.

(2) In the hands of a competent person it is a perfectly safe apparatus.

(3) It is possible with this apparatus to regulate the anæsthesia from the lightest to the most profound.

(4) The anæsthesia is graduated and not jerky.

(5) There is very little tendency to sickness either during or after the anæsthesia, and so it is especially useful in abdominal cases.

(6) It is especially useful in cases associated with shock, where nicety of administration is necessary.

(7) A minimum of chloroform is presented to the patient, and the air of the operating room is unaffected.

(8) There are little or no after-results.

### ETHER.

The main object of this paper was to introduce to your notice chloroform and its effects, and what little I am about to say about ether is not either to uphold or disparage it, but to speak of it in relation to chloroform.

Ether was discovered and used before chloroform, having been found by Valerius Cordus in 1540, and used in 1846, whilst the latter did not see the light of intelligent day till 1831, and used for anæsthesia for the first time in 1847; and in the South it has held its own, having a much better reputation in the coroner's court. Whilst it has certain toxic effects in extreme doses, they are always of such an evanescent nature as to cause no particular alarm. Any deaths that have occurred in connection with it are, I believe, generally considered as deaths from asphyxia pure and simple.

It is more irritating to the superficial reflexes, but produces a quicker anæsthesia. It is always preferable to precede it by gas or ethyl chloride, and so protect the throat from its irritating fumes. There are many conditions which are supposed to contraindicate ether, but many of these, such as bronchial catarrh, asthma, &c., are imaginary contraindications, the trouble in such cases being due to careless administration.

In weak people and old people and young children I prefer chloroform, not because they would not succumb to the ether, but it is more congenial to them, it causes less stress and the reaction is not so great. Any stimulating



effect of ether has to be paid for at the other end. In a serious operation on a weakly person I should feel safer with chloroform than ether, because the fear of shock at the critical moment, as in paring off adherent peritoneum, is not so marked with chloroform, and in fact all the cases of bad shock in such operations that have come under my notice have been under ether, whilst I have seen the most trying cases go through with chloroform without trouble. In abdominal operations, where the after-passivity of the patient is desirable, I would use chloroform on account of its slighter after-effects, especially if given in minimum concentrations. A series of experiments or investigations conducted by Dr. Silk at St. Thomas's Hospital and incorporated in a paper read, whilst President, before the Anæsthetic Society, brought to light some surprising results. It was decided that ether, whilst not so dangerous during the anæsthesia, in this sense being a safer anæsthetic, became culpable when examined in the light of the after-results. It caused more marked and persistent nausea, marked and sometimes serious lung complications. The after-depression was greater (an important point), and he summed up by saying that it was very questionable whether, after all, ether was not the greater criminal. It was curious, however, that the cases of lung complications were not those expected, a number of chronic bronchitics going through with it in perfect safety, whilst others not subject had had attacks. I have myself seen a small asthmatic attack induced by ether in a patient who afterwards denied any proclivity.

On the score of after-results I would from my own experience give the palm to chloroform, especially when given by the graduated method, the general immunity from sickness being so prominent that it was remarked, unsolicited, by the nurses (a not disinterested section of the Hospital staff).

Lately some cases of paresis of the hand and arm have taken place in connection with operations, and it has been suggested that this was due to the toxic effect of the anæsthetic. I know of no such effect possible that would not have first affected the heart.



I would, in concluding, advise that anyone not well informed with the effects and peculiar nature of chloroform should select ether as a safer measure; the difficulty of managing ether is secondary to the danger of chloroform. But given such knowledge, chloroform is my favourite as an all-round anæsthetic; but in administering it one of the percentage instruments should always be used, and I consider that the ordinary open method should be discouraged. From experience I prefer Krohne's, because I know most about it, but do not pretend for a moment that this is the last word that has been said on the subject. I think at the same time its adverse criticism, as in the case of homœopathy, by those who are ignorant of it, a chief recommendation.

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Dr. SPIERS ALEXANDER (from the chair) said that the sight of the ingenious apparatus on the table suggested to his mind that Dr. Beale had advanced greatly upon his instructors, because in all the Scottish Universities anæsthetics were used by the open method, and chloroform was the anæsthetic that was preferred there. In Edinburgh and Glasgow Universities chloroform was preferred, because it was introduced by the late Sir James Y. Simpson, who always gave it by the open method on a towel. He believed that that method was in vogue there still and gave excellent results. In England, methods which were, perhaps, more advanced had been adopted, and no doubt with some advantages. In Germany, and more especially in Berlin, ether seemed to be the anæsthetic which was preferred. There they often had rather casual methods of administering it. He had seen it administered repeatedly by a bag in which a sponge was placed. The ether was poured upon the sponge and the bag was applied over the patient's nose and mouth, sometimes by the porter standing by. The patient was allowed to breathe in the bag, and the result seemed to be all that could be desired. They did not seem to employ any more elaborate method than that, as far as he was able to observe.

Dr. MADDEN asked Dr. Beale whether he had been in the habit of giving the ethyl chloride or the gas before chloroform, as in the manner of giving it before ether? It was not usual, he believed, to give gas before chloroform, though it was common enough before ether. In his (Dr. Madden's) experience of using

Krohne's apparatus, he found that it took a long time to get sufficient unconsciousness. He should also like to ask what form of paresis Dr. Beale spoke of, because that was a condition which he (Dr. Madden) had very rarely seen. At the present moment he had a case in the hospital, operated upon by Dr. Burford, in whom there had been considerable collapse after the operation. He injected strychnine, and the patient now had partial paresis of the left arm, the strychnine having been injected in the left leg. He had been inclined to attribute the paresis to the effect of the strychnine, but possibly it was due to the ether. He should like to be enlightened upon the question whether ether given for a long period could produce paresis on the arm.

Dr. NEATBY joined in thanking Dr. Beale for his very learned paper. Dr. Neatby's experience in observing the effect of the anæsthetic differed a little from what Dr. Beale had stated. In the first place with regard to the abolition of corneal reflex. He understood Dr. Beale to say that it was not necessary to induce that abolition. He (Dr. Neatby) should have said that that was one of the most unreliable guides that they had of the patient being under an anæsthetic. He had often found that the corneal reflex appeared entirely abolished, and that the patient had other reflexes which it was extremely inconvenient to have acting at the time of commencing an operation. Again, as to which was the more suitable anæsthetic, ether or chloroform, he should have liked to have more definite instructions from Dr. Beale. From what he (Dr. Neatby) had been able to observe, the change of anæsthetics from time to time was the thing which answered the surgeon's purpose best, keeping the patient in good condition, keeping up her strength and yet keeping her well under the influence of the anæsthetic, quite free from reflexes. Then he thought that there was no doubt, with regard to abdominal cases especially, the use of a large proportion of chloroform during operation was highly desirable, because of the lessened amount of after-vomiting. He thought that there was no doubt, from what he had seen, that the results of vomiting were much less after chloroform than after ether. He should like to make a remark on the paresis which had been referred to. He had seen one case of very marked temporary paralysis of the muscles of the right arm after a lengthy operation, and he put it down at the time to the position which is adopted in pinning up the arm to get it out of the way of the operator during the operation. The arm was pinned back on to the pillow. It was quite a new theory to him to hear that the paresis could possibly be supposed to be

due in any way to the anæsthetic. As to the administration of strychnine, in his case no strychnine either in the arm or leg was administered at all. He was still inclined to regard the paresis as an effect of unusually long pressure.

Dr. JAGIELSKI thought that the observations in relation to temperature were very interesting indeed ; he meant the extent to which the temperature was lowered by chloroform or by ether. It was interesting to note how far down the temperature might be lowered.

Dr. WYNNE THOMAS said that Dr. Beale had made little reference to mixtures of anæsthetics such as the mixture of ether and chloroform, or in some cases with alcohol. He knew that Mr. Lawson Tait told them that a mixture that he had used in his hospital for some years was a mixture of one part of chloroform and two parts of ether, and that he had found it more satisfactory than pure ether or pure chloroform, and that it combined the advantages of each without the disadvantages. He should like to know what Dr. Beale's experience in this respect was.

Dr. BEALE in reply referred to what Dr. Madden had asked with regard to ethyl chloride in relation to chloroform. He knew from his own experience that Krohne's apparatus was too slow. He used to say to Krohne, "I shall never use your apparatus, because it takes a deuce of a time." Krohne said, "No, it only takes five minutes." He (Dr. Beale) said, "Very well, you shall have a chance" ; so he invited Krohne to a case of a child, and he took twenty-two minutes to get the patient under, with his own apparatus. His (Dr. Beale's) experience had been that seven minutes was the most that was required, and that was exceptional. An American visitor said that he (Dr. Beale) only took two minutes and a half. That was not perfect anæsthesia, but it was sufficient to get the patient ready. The ethyl chloride he had often given for that purpose. Some of the surgeons complained of the time, and he had given ethyl chloride before chloroform and before ether. He preferred it before ether. Sometimes they got some alarming symptoms with ethyl chloride, but there was nothing much to worry about. There was dilatation of the pupils with loss of eye reflexes. As to the question of paresis, he had only casually mentioned it. It was only to show as a sequence to his paper that the amount of toxic action necessary to produce paresis of the nerve would in all probability affect the heart first, and so risk death. There had been distinct experiments with regard to nerves extracted after death and treated with chloroform vapour, and it had been found that a certain percentage—a rather high percentage—was necessary to destroy the irritability of the nerve.

Such concentration would produce a lethal effect on the heart. Dr. Neatby had referred to corneal reflexes. He (Dr. Beale) had found in a certain number of cases the corneal reflex was dissipated in a most extraordinary way without the patient being deeply under. But this, in his experience, was unusual. It represented, perhaps, the eccentricity of the patient. He found that the majority of patients retained the corneal reflex whilst the sclerotic reflex was abolished, and this was an ideal condition which was impossible with the open method, because they must have a certain percentage to acquire that happy condition. He believed that Dr. Neatby referred to paresis, and he would like to say that he was making an investigation, and he would be glad if anybody would send him any notes of cases in which paresis was in any way due to an anæsthetic. Dr. Neatby did not believe that it was due to the anæsthetic, and attributed it to something else. Two cases came under Dr. Burford's notice, and in both cases there was evidence after the operation of some toxic infection, and it was just possible that it might be due to some exposure of the patient during the anæsthetic. The case which came especially under his notice was one in which there was paralysis of the set of muscles which were associated with the external cord of the brachial plexus and affecting especially the super-muscles of the scapula. Dr. Jagielski had spoken on the subject of temperature. It was an interesting point that he (Dr. Beale) had found in ether a greater and more marked reduction in temperature; and he found that when the patients were examined at intervals ether showed great variation. After less ether the temperature recovered itself very quickly. In the case of chloroform it was not so. There was more permanent reduction.

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MOVABLE KIDNEY.<sup>1</sup>

BY WILLIAM CASH REED, M.D., C.M. EDIN.

*Honorary Assistant Surgeon and Joint Gynæcologist to the Hahnemann Hospital, Liverpool.*SYLLABUS.<sup>2</sup>*Introduction.**Frequency.**Topography* : Views of Bourcart, Wolkow, and Delitzin.*Causes* : (1) Radical or Structural. (2) Anatomical—(a) Intra-abdominal pressure; (b) Subinvolution. (3) Corset—view of Stratz. (4) Emaciation—its rôle.*Complications* : Effect on (1) Suprarenal gland. (2) Ureter. (3) Large intestine.*Diagnosis* : (1) Methodical. (2) Urinary analysis.*Symptoms.**Treatment* : (1) Mechanical. (2) Operative. (3) Medicinal.

## INTRODUCTION.

GENTLEMEN,—The subject of my paper this evening is “movable kidney”; and I hope, with the aid of lantern slides and clinical examples, to give to a subject which is admittedly somewhat obscure, and to many not particularly interesting, a vitality which will ensure interest. The importance of the subject is very great, because upon its recognition depends the only possible clue to pain which is often very severe, and to associated phenomena which are no less distressing to the patient. I would go a step further and say that unless recognised, all the art of the physician to relieve the pain induced by movable kidney is absolutely wasted.

Now, as regards the subject of my paper, there are certain limitations which I should like thus early to define. By a “movable kidney” I do not mean a “floating” kidney, nor one which moves merely, for all do that, nor yet one which can be simply felt—in other words, the “palpable”

<sup>1</sup> Presented to the Liverpool Branch, March 9, 1905.<sup>2</sup> This paper was illustrated by lantern slides and the exhibition of cases. The author is precluded from publishing any reproductions of the slides, owing to their having been taken from a foreign source.

variety, for it is generally possible by bimanual examination in a thin subject to *feel* the organ easily.

With regard to the "floating" variety, or, as it is sometimes called, the "wandering" kidney, it is a congenital condition; the organ is covered by peritoneum, it is attached by a so-called mesonephron, and it floats about in the abdominal cavity just as do the coils of the small intestine. In stating that all kidneys move I refer, of course, to that which is physiological, and is due to contraction and descent of the diaphragm. This range of movement is of course very limited, and I mention it here partly for definition's sake, and partly because under the head of treatment this characteristic is taken into consideration.

Precisely then, the movable kidney referred to in this paper is one which, though cut off from the cavity of the peritoneum, which is normally the case, of course, and situated between the peritoneum in front and the abdominal parietes behind, also normal, *yet* possesses a range of movement which is greater than physiological. It varies from an inch or two to a degree, which will allow of the organ occupying the pelvic cavity.

#### FREQUENCY.

Movable kidney is far from uncommon; it occurs much more often in women than in men, and chiefly in women who have borne children. One observer, Skorczewsky, says that he examined 1,422 patients during life; 1,030 of these were females and 392 males. Thirty-two out of the former and three out of the latter were the subjects of movable kidney; in other words, it is about four times as common in women as in men. Personally, I should have thought it about twenty times more common, but, then, one is constantly examining women with the object of ascertaining, not so men, hence this observation must be taken for what it is worth. It should be remarked here that in speaking of men I do not include the young male adolescent, and shall refer to this point later, and also to the fact that, as we shall see later, the anatomy of the loins and pelvis of the male

adult is such as to lend greater support to the organ in the male than in the female.

#### TOPOGRAPHY.

Before proceeding it is necessary to refer to the topography of the renal region. To do so at length would be wearisome, and would, after all, be a recapitulation of facts learnt in our student days, perhaps with more labour than heartiness, and as a means to an end rather than from an intrinsic fascination of the subject itself. Be that as it may, we merely need a few reminders now; thus, the first illustration shown is a well-known one from Ellis and Ford's plates. The right kidney, with which we are chiefly concerned, has been removed; the left is still intact. The muscles associated with displacement are well shown, and, as they will be referred to incidentally in course, I may at the moment particularise them, viz., the quadratus lumborum, the iliacus and facile princeps, the psoas, great and small. One may also observe here that the vault of the diaphragm is higher on the right side than on the left, and, further, though this is not shown in the plate, that on the right iliacus muscle the cæcum rests, and on the left the sigmoid flexure of the colon.

Having thus briefly spoken of the structures forming the bed or lodgment of the kidney, it is necessary to refer to the relations of the latter with adjacent organs. The object is to show, as I intend to do later on, why it is that a displaced kidney originates so much suffering referable to other viscera. This is clear enough when the anatomical relations with respect to each other are borne in mind. Much that is otherwise obscure is made plain, and there is less temptation to refer to associated pains as reflex or sympathetic, for they are indeed due to nothing more romantic than anatomical contiguity.

“The anterior surface of the kidney is convex, partially covered by peritoneum, and is in relation on the right side with the back part of the right lobe of the liver, the descending portion of the duodenum, and the ascending colon, and on the left side with the great end of the stomach, the tail



of the pancreas, and the descending colon. The superior extremity is embraced, as is well known, by the suprarenal gland, and corresponds to the eleventh rib" (Gray).

I have endeavoured to make the above data pictorial by slides of two plates found in the work of Professor Bourcart, of Geneva, and entitled "Le Ventre." This book is largely a translation into French of a work originally written in Russian by Drs. Wolkow and Delitzin, and published in 1899. Prior to the French translation there had been one into German, and from it the former was made. With slight exception, the description of the relations of the kidney as given in "Gray's Anatomy," just quoted, corresponds with the two figures thrown on the screen.

#### CAUSES.

We now come to some of the causes of movable kidney, and I have divided them as follows: (1) *Radical* or structural; (2) *anatomical*—(a) intra-abdominal pressure, (b) subinvolution; (3) the *corset*; (4) *emaciation*—its *rôle*.

This list, of course, lays no claim to being exhaustive, but only to embrace the most important causes. Thus we speak first of *radical or structural*. By this I mean certain defects which are common to the genus *Homo*, and appear to me to belong to that strange category which includes a liability in some people to hernia.

They are not due to anything acquired as the outcome of recent civilisation that is, though what *rôle* evolution down the ages may play I do not presume to suggest.

Before describing the strange-looking figures which follow, it is necessary to introduce them by saying that they are the reproductions of certain plaster of Paris casts made by the authors before mentioned. The object of these investigators was to study the characteristics of the bed or lodgment of the kidney, and to find out what anatomical peculiarities might exist which would tend to dislodgment of the organ. The method adopted is an in-



genious one. The viscera having been removed from the abdominal cavity of a cadaver, and the brim of the pelvis closed in by some impervious material, as it were by a shelf, plaster of Paris is poured into the space thus isolated, and allowed to harden. The body is placed sometimes in the horizontal, sometimes in the vertical plane.

The resulting cast is by-and-bye removed, and in these slides we have thus presented the obverse of the paravertebral depressions, the upper part representing the renal bed. It is but fair here to remark that the original casts have evidently lost something in the reproduction, and probably these slides something more. It is not easy always to follow exactly some points which were evidently clear enough in the original casts. One must take something for granted, although as a matter of fact details essential to the argument, based upon the casts, is quite clear.

The protuberances on each side correspond, of course, above to the diaphragm, and from above downwards to the paravertebral depressions. In the upper part of these the right and left kidneys would be respectively embedded. The sulcus in the middle corresponds to the vertebral column.

A consideration of these slides serves to establish certain data. In the first place, there is a difference between the renal bed of the male and of the female. In the case of the male it is broader above than below; in other words, it is pear-shaped, more or less, with the narrower end pointing downwards. Besides, there is but little variation in its characteristics, whether the subject be standing or lying, and, speaking generally, the two sides correspond. Thus we have in men anatomical peculiarities which tend to disfavour displacement of the organ.

In the female, on the other hand, the case is different. The chief point to remark is that the renal bed is more open below than above, its shape is less pyriform; or, rather, it is cylindrical, and more so still in the standing position of the body. Moreover, this cylindrical shape is more marked on the right than on the left side.

Thus, briefly, in women an openness below of the renal

bed, more marked on the right than the left side, forms a radical or structural peculiarity which tends towards displacement of the organ.

We now come to the *second* or *anatomical cause* of the condition under consideration. This, as before mentioned, is divided into two, viz. (a) *intra-abdominal pressure* and (b) *subinvolution*.

First, with regard to the former. There is a good deal which is debatable as regards this, or rather one aspect of it, viz., the intra-abdominal *atmospheric* pressure. I do not feel competent to enter into this, nor is it necessary, for it can only very remotely affect the subject in hand. One statement, however, may be made without prejudice, viz., that I have frequently noticed in abdominal operations that as soon as ever the peritoneal cavity is opened there is a rush of air into the latter, which is heard with the greatest distinctness. Thus the pressure in these cases is greater without than within. That, however, which we wish to speak of here is not the atmospheric pressure, but the pressure of the intra-abdominal organs, the one upon the other. Such must depend partly upon gravity and partly upon resistance, and elasticity. Compare, for example, the density of the liver with that of the duodenum and small intestine. Chiefly, however, for our purpose, what is of prime importance is the state of elasticity of the abdominal parietes, because the relationship of the intra-abdominal organs, though subservient to gravity and resistance, depends principally upon the state of tonicity of the parietes. The question is, in what degree do the latter maintain their normal supporting power? And here I refer not only to the anterior, but also to the posterior and lateral walls as well. We have already seen that movable kidney occurs mostly in women who have borne children, in those, in fact, to whom parturition has left its legacy of relaxed abdominal muscles. In the next slide I show the condition, common enough, unfortunately, in these circumstances, of the wallet-shaped abdomen, or, in plainer English, the "pendulous belly." This is deplorably common amongst the poor, and is not due, I believe, solely to poor food and curtailed rest

after confinement, but largely to an underlying discrasia to be referred to shortly.

From what has been said it will, I think, be clear that an abdomen which is pendulous favours discord as regards the mutual accommodation of its contents. As the coils of intestine follow the sagging parietes, or even emerge through the interval between the recti muscles, forming thus a true entero-ptosis, so a kidney, assisted by the anatomical peculiarities of its bed, tends to slide downwards and forwards.

I now come to speak more particularly of the second subdivision, viz., *subinvolution*.

Strictly speaking, it has already been alluded to in the foregoing, but I wish to refer to it now in a wider sense. We speak always of subinvolution of the uterus when wishing to convey that this organ, since the expulsion of its contents, has failed to return to its normal size and consistency. In point of fact, the uterus is but one of several organs which have been lacking in this respect. Besides the large, flabby, and frequently toppled over uterus, and the redundant and scarred *anterior* parietes, we have a similar condition of the *lateral* and *posterior* parietes. The bearing of this upon movable kidney can hardly be unimportant. But there is another subinvolted muscle which plays, I believe, an even more important part than those already referred to, viz., the *diaphragm*. This, I believe, accounts for the dyspnoea on exertion so frequently complained of by young women during the stressful years of childbearing. Moreover, a subinvolted diaphragm must contribute to a faulty intra-abdominal pressure, and thus indirectly favour renal displacement.

I cannot prove that movable kidney is commoner than it used to be, say twenty years ago, but I think it is, and I feel sure that underlying the subinvolution as a cause there is another factor upon which even the subinvolution itself depends. I refer to *neurasthenia*—a convenient term, one may say, to express ignorance. Be that as it may, it is a convenient term also, since it embraces symptoms wide as the poles asunder, and unites them at one point, which we label, for practical purposes, *nerve exhaustion*. I for one am convinced that in neurasthenia we have a pathological entity.

Whether, however, movable kidney is commoner than formerly or no, one thing is clear, viz., that exhaustion of the young mother is greater than it used to be, and hand feeding of the infant is vastly more common. Thus one of the chief stimuli to uterine contraction is removed and involution is arrested.

And now to a short review of the third cause of kidney displacement, viz., the much abused *corset*. Endless controversy has ranged round this apparently innocent structure. Worn as the average woman in this country wears it, I cannot see that the corset does any harm whatever, nor does it in such case appear to me to have any causal relationship with the subject of my paper. We all know, however, that sometimes a physician finds himself sorely perplexed as to how to deal with this terrible constriction without giving dire offence to his patient. Perhaps the following translation of some wise if rather sarcastic words of Dr. Stratz explains matters: "Fashion," says he, "has been created less with the object of bringing beauty into evidence than to hide its *defects*, and thus it is that all warfare waged against its mistakes ends only in defeat, and efforts the most laudable remain sterile. A beautiful body will always be beautiful however clothed, but, as the proprietors of the latter will always be in the minority, they will be obliged to submit to the numerical advantage of their sisters, who are not only more numerous, but would make believe *more beautiful* than Nature made them."

I mentioned earlier that the superior pole of the kidney corresponds with the eleventh rib. If undue constriction of this region during adolescence be indulged in, its baneful influence in pressing the kidney from its bed may be obvious later. If, however, a milder constriction be exercised lower than this level, and especially if the corset be put on in the recumbent position, it appears to me that it would act rather as a hindrance than otherwise to displacement of the kidney.

A reference to the chief causes of ptosis of the kidney would scarcely be complete without a word as to another reason frequently assigned for its occurrence. I refer to the absorption of the peri-renal fat. This was said to act as a natural support to the organ embedded within it. The

researches of the authors already referred to tends to dispel this view, and to show that the perirenal fat has little, if anything, to do with the support of the kidney itself. These authors, having fastened the cadaver to a plank, which has in its centre a universal joint, moved the former about in various positions and planes. When a new position was adopted an injection in the renal region of colouring matter was made. By a study of these the variations in the level of the kidney in different positions of the body were noted. I have not dwelt upon these researches because it would appear that they must be greatly, if not entirely, vitiated by the fact that living and dead fat are for practical purposes totally different things. In the living it appears to me we have in the semifluid pink material traversed, though it be by fine trabeculæ, a substance of very little, if any, supporting power. I can quite understand if the absorption of fat took place very suddenly that the kidney would be more liable to fall than it had been, but the fat cannot disappear suddenly. A sudden removal of ascitic fluid or the delivery of a child would, however, have their effect upon the intra-abdominal equilibrium, and merit, perhaps, as causes, a more lengthy consideration than time permits.

The truth, I submit, lies in the fact that the neurasthenia is not only responsible for the subinvolution, but for the emaciation also, and that the latter is an accompaniment rather than a cause of movable kidney.

Thus, to summarise, the causes are :—

(1) Radical or structural, as shown in the plaster of Paris casts.

(2) Neurasthenia, leading to subinvolution and defective intra-abdominal pressure.

(3) The corset, in a very limited sense, and in certain well-defined conditions.

(4) Emaciation a possible cause, but in a still more limited sense even.

#### COMPLICATIONS.

I now come to speak of a few of the *complications* of movable kidney, and as these concern essentially either the

organ itself, broadly speaking, or the large intestine, we may consider them under these heads.

As regards the *first*, we may take it as granted that the kidney itself suffers no ill-effect fairly attributable to abnormal location ; not so, however, its adnexa, viz., the suprarenal gland, and the structures grouped together at the pelvis. In this slide is shown a right kidney in a state of ptosis. The primary cause in this particular instance is the lengthening out of the right lobe of the liver. It will be noted in passing that there is pressure on the vena cava, and in one case recorded by the same writer this pressure hindered the circulation to such a degree that the patient suffered from well-marked œdema of the limbs for many years, and only when its true cause was recognised and the kidney replaced, did it begin to subside, ultimately disappearing altogether. The point, however, which I specially wish to bring out here, and which is well indicated, is the condition of the *suprarenal capsule*. It is very remarkable how this gland resists dislodgment and declines to submit to being severed from its connections. Although being attached to the kidney, it is obliged to follow the descent of the latter, it becomes stretched and elongated proportionally, but still retains its connections above and below, and is never actually displaced. This fact appears to me very important and interesting in view of what is now known of the physiological action of suprarenal extract, and also in view of so-called "internal secretion," as it occurs in the gland under consideration. I submit that the latter from a stretched out suprarenal gland may be so modified, or rather vitiated, that it is accountable for some of the symptoms met with in ptosis of the kidney.

Now for the effect upon the *ureter*. We may take it, I think, as proved that movable kidney, pure and simple, gives rise to no known distinctive pathology of the *urinary secretion*. It is noteworthy that, even in an extreme case of ptosis, the urine is essentially normal—it contains, that is, no constituent which can reasonably be assumed to be due to abnormal location. I shall refer to this point again later.

When the structures at the hilum of the kidney are studied it does not seem very obvious why, if their relationship be normal, any mechanical obstruction should be brought about by displacement, yet this does occur with very serious results, and I show two slides here in illustration. In No. 9 a mechanical hydronephrosis has taken place, due to ptosis, and a curvature of the ureter over the renal vessels, and a kink in it in consequence. The next, No. 10, is no less interesting; it shows incidentally the elongation and stretching of the suprarenal gland already described, but it is to indicate chiefly an abnormality of the ureter in relation to the vessels. This presumably would also tend to the formation of a hydronephrosis.

With regard to the effect of *pressure upon the large intestine*. This slide is from a case of wallet-shaped abdomen or "pot-belly," with ribs deformed by tight-lacing. The stomach, liver, and kidneys are all more or less in a state of ptosis, and the first is obviously dilated. That portion of the colon under the right false ribs is clearly exposed to very considerable danger from pressure. Slide No. 12 shows the left kidney dropped and the serious pressure induced thereby at a point where the transverse colon merges into the descending.

#### DIAGNOSIS.

I need not detain you long over this, but merely indicate the usual method employed, and under this head also say what is necessary with regard to analysis of the urine in these cases. In slide 13 the patient is really half lying, a position which tends, of course, to relax the abdominal muscles. It is more usual in this country to examine a patient lying flat, not because it is easier, but because it so happens, in the majority of cases, that examination of the kidney suggests itself in the course of a pelvic examination, when the patient is lying on the back with the knees drawn up. The hands being warm, the patient's attention engaged, and the abdomen not needlessly exposed, the left hand presses posteriorly into the space just below the last



rib. Thus the kidney is pushed forwards, and the patient is now asked to take a deep breath. This depresses the diaphragm and liver, and with them the kidney. The right hand now presses below the anterior costal edge, when, if the organ is movable, it is readily felt between the two hands.

Now as to the *urine*. I have already said that a movable kidney excretes healthy urine, and that, if there be anything abnormal in the analysis, it is due to circumstances which are extraneous. The urine ought, however, invariably to be examined.

Mobility of the kidney and albuminuria may, of course, be associated, and it is held by some that in certain cases the relationship is that of cause and effect. Thus, in the case of the young adolescent, the so-called "postural albuminuria of puberty" occurring in the morning when the erect posture is assumed, tends to confirm this view. I can only say that I have many times sought for this relationship in my cases, but have not found it.

The most severe case of renal ptosis in a lady with which I am acquainted resisted a most searching examination by Dr. Whitaker to find albumen. He tested it with nitric acid, picric acid, and by boiling with acetic acid, and not even the faintest trace could be found, and yet this patient's right kidney was lying on the pelvic brim.

If albumen be present, the cause then must be sought elsewhere, *e.g.*, in one case there is a very distinct deposit constantly present, yet it is significantly diminishing since the kidney has been supported and the patient has taken arsenicum. In this patient there is a history of post scarlatinal nephritis many years ago. She is now 27. Here, then, we have a case probably of the large white kidney which tends to droop in consequence of its weight, and is an example of a pathological kidney with albumen, and its mobility is merely a feature of the complaint.

#### SYMPTOMS.

As the analysis of urine is not distinctive, neither are the symptoms. To give a list of them would be dry reading.



The best plan will be to take an imaginary, or rather a "type case." A woman has borne two or three children, probably rather rapidly. She has been subject to an excess of the ordinary cares and anxieties of life, and to a temperament already neurotic over-anxiety and nervousness are now added. I use the term "nervous" in a restricted sense, for she may be a Spartan in endurance, who will face any danger or emergency with calm heroism. Thus hysteria is not in the vocabulary. In early womanhood she was well covered, even plump, but of late years has been getting thin, and is now emaciated.

She has a subinvolted and bulky uterus, and complains of bearing down and backache. The levatores ani are also subinvolted, and there are consequently cystocele and rectocele. She especially complains, however, when interrogated, of an ill-defined abdominal pain, at times acute, and always nagging. It is referred to the epigastrium, gall-bladder, or transverse colon. Sometimes she is aware that something moves from side to side as she turns. The pain described is absolutely independent of food, being neither improved nor disimproved by its presence or absence, and it is uninfluenced by its quality. The pain, however, and this is the crux, goes when she lies down or goes to bed, and the hours spent thus are the only blissful ones of the twenty-four. As soon as she rises in the morning the pain begins again.

Thus I have endeavoured to summarise the symptoms. They are not, of course, inconsistent with other conditions, notably stone in the kidney and duodenal ulcer, and these, therefore, must be borne in mind. Two other points may be mentioned, one a detail of some interest, the other by way of caution. One lady told me that ever since the birth of her only child, now fourteen years ago, she has feared to arrange anything on her sideboard, because the merest touch of the abdomen at the level of this piece of furniture gave rise to so much pain. In fact, arranging flowers here and "stomach ache" always went together. And yet the peccant organ had never been brought to book, and "indigestion" was the cause assigned.

A movable kidney may, however, give rise to no symp-

toms whatever. I well recall years ago seeing a patient with Dr. Cash, of Torquay, with both kidneys lying at the pelvic brim, but with no local symptoms at all.

### TREATMENT.

Gentlemen, I fear my paper is getting too long. I will, therefore, be quite "sketchy" under this last head. Essentially the treatment is (*a*) *mechanical*, (*β*) *operative*, and (*γ*) *medicinal*.

The first comprises three subdivisions, viz. (1) the abdominal bandage, (2) massage, (3) breathing exercises.

The first I show in the next three slides. It can be applied next the skin or with a thin garment beneath. It may be commenced either on the right or the left side, but it *must* be applied when the patient is lying down, and it *must* be tight at its lower margin. If it is not put on in the recumbent position the kidney will not be held rightly in place; if it is not tight where necessary the band will be found in a few hours under the patient's armpits.

(2) *Massage*.—This I learnt from Martin, of Berlin, and it is of immense use in the pot-belly so frequently referred to.

(3) *Breathing Exercises*.—The object of these is, of course, to give tone to the abdominal muscles, and especially to the diaphragm. Whiteley's exerciser, the systems known as Swaboda's or Conn's each have their place.

### *Operative.*

I have stitched the kidney in position two or three times, and am not charmed with the result, chiefly, as it seems to me, because it is unnatural to *fix* the kidney.

Nature has assigned to it a certain limited but quite definite range of movement, as we have seen, and it does not appear to me common-sense to render it immovable. Where the recti muscles are very widely separated and the bowels fall through the interval, in other words, in a severe case of entero-ptosis, it is right, according to some, after denudation and making a raw surface, to stitch the muscles together.

I have never done this, at least not for the condition due to subinvolution.

*Medicinal.*

I believe in arnica, and, for the nephralgia, am impressed with arsenic. Nitrate of strychnia is extremely valuable, and mostly, I believe, in cases where the duodenum is chiefly implicated.

Cantharis, berberis, phosphorus, terebinth, and picric acid all have their spheres of action for symptoms which often accompany, and are frequently, if not always, caused by the movable kidney.

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## INTRODUCTION TO A DISCUSSION UPON DIABETES.<sup>1</sup>

BY J. GALLEY BLACKLEY, M.B.LOND.

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GENTLEMEN,—The subject upon which I have been asked to open a discussion this evening is one which has for centuries given rise to much wordy warfare, and possesses quite an extensive literature of its own. If the syllabus which has been placed in your hands is rather suggestive of a clinical lecture, than which nothing is further from my thoughts, I will ask you to bear with me whilst I endeavour to bring out points likely to provoke discussion.

In order to clear the ground, let us admit that in speaking of diabetes we understand *diabetes mellitus*, *i.e.*, a condition of glycosuria which has been in existence at least twelve months, and a condition which is usually characterised sooner or later by the appearance of diacetic acid in the blood. The intermittent forms of glycosuria should not be regarded as genuine diabetes; they are much more amenable to treatment, and many are the remedies which have been vaunted in turn as cures for diabetes, when they have, in

<sup>1</sup> Presented to the Section of Medicine and Pathology, April 6, 1905.

fact, only helped to remove a transient or intermittent glycosuria. Homœopathic literature is unusually fertile in records of cases which are, to say the least, open to serious criticism.

In the matter of etiology it is generally admitted that *climate* exercises no influence, as the disease is found in all latitudes and in all countries, also that no social rank is exempt. *Sex* appears to have an influence to this extent, that in men it is commoner in adult life, whilst in the opposite sex it is commoner in young girls. It is found at all *ages*, from early infancy to extreme old age. A sedentary life is certainly conducive to the disease, and for this, amongst other reasons, the Jews, as a race, are particularly prone to it. Faulty *diet*, especially in the matter of the abuse of sugar and starch, is undoubtedly the most potent of all predisposing causes, but excessive diet in any shape must not be overlooked. Excessive diet causes retarded nutrition, and the disease is undoubtedly one of the somewhat large group having retarded nutrition as its basis, viz., rheumatism, obesity, diabetes, gravel, gout, asthma, eczema, migraine, gall-stones, and, in common with all these diseases, heredity plays a prominent part in the etiology.

*Conjugal diabetes* is sufficiently common to have raised the question whether diabetes is not a communicable disease, due to a micro-organism. Toxic glycosuria is familiar to all readers of homœopathic literature; it is a prominent symptom in the accounts of poisoning by curare, carbonic oxide, chloroform, amyl nitrite, hydrochloric acid, phosphoric acid, turpentine, corrosive sublimate, uranium nitrate, morphia, strychnine, chloral hydrate, lactic acid, and phloridzin. How far the general conditions present in any of the above (the *totality of the symptoms*, in fact) correspond to genuine diabetes so as to warrant us in relying upon the help of these drugs in treatment will, I hope, come out in the discussion.

The pathological anatomy of diabetes is too extensive to be gone into in detail here, and many of the appearances recorded are obviously secondary, but we cannot pass over the lesions found *post mortem* in the pancreas and in or

about the medulla oblongata and vagi. The existence of alteration of the pancreas in diabetes was first pointed out by an Englishman, Cowley, in 1788, and this was afterwards confirmed by Bright. These changes oftenest consist in *atrophy*, either total or partial, in the latter case being specially limited to the tail of the organ. The pancreas may be transformed into a whitish mass of fibrous hardness, in which the excretory canals can no longer be distinguished; there is sclerosis of the connective tissue, the glandular cells being choked and in a state of fatty degeneration. Obliteration of the excretory canals by calculi and the formation of cysts from the same cause are frequently noticed. The compression of the canal of Wirsung by a cancerous tumour of the head of the pancreas may cause atrophy with total suppression of the secretion, and bring about diabetes.

Where the atrophy is partial, there is vascular and perivascular sclerosis in the interacinous and intercellular spaces, the element involved being those clusters of irregularly polygonal cells which lie among the acini at the splenic end, are closely related to the blood-vessels, and are known as the "islands of Langerhans," and which will be referred to again presently.

Morbid conditions in the neighbourhood of the bulb which can be regarded as primary are very rare, but they have undoubtedly been found. They may be tumours or sclerotic affections extending into the bulb from the cord. Bulbar paralysis, however, where we should expect to find sugar in the urine, appears to be seldom or never a cause of diabetes or glycosuria.

The condition of the blood in diabetes has, for obvious reasons, attracted much attention. It is found uniformly less alkaline than normal, and the proportion of glucose contained in it is much increased. Healthy arterial blood contains about 1.30 grammes per litre; in diabetes the proportion is raised to 2.50, 3, or even 5, grammes per litre. The specific gravity of the blood is also raised to 1033 or to 1035.

A brief reference to the experimental causation of glycosuria may with advantage be made here.

(a) The classical experiment of Claude Bernard (1849) of puncture of the floor of the fourth ventricle; here we obtain after an interval of thirty to forty minutes a transient glycosuria lasting twenty-four hours at most.

(β) Total extirpation of the pancreas; after this operation a dog weighing 7 kilos. will void 1,000 to 1,200 cc. of urine containing 70 to 80 grammes of sugar.

(γ) Phloridzin diabetes: this is of interest because it leads to glycosuria, not by its own disintegration, but by producing changes in the animal body whereby the excretion of sugar is increased. Thus the administration of 1 gramme leads to the excretion of 100 grammes of glucose in the urine. This takes place most strongly after fatty food; but it may occur without the ingestion of carbohydrates, and even after extirpation of the liver.

It is exceedingly probable that, as in some varieties of diabetes, phloridzin produces glucose at the expense of the body proteids.

The theories which have been put forward from time to time as explanatory of diabetes are four in number.

(1) *Vaso-hepatic theory* of Claude Bernard, where diabetes is regarded as owing to excessive formation of sugar in the liver, due to increased vascularity of vaso-motor origin.

(2) *Neuro-secretory Theory*.—According to this theory the liver is supplied with definite glyco-secretory nerves independent of the vaso-motors. Though the existence of these nerves has not been anatomically demonstrated, it is an undoubted fact that lesion of nerve matter in certain regions is very liable to induce glycæmia and glycosuria.

(3) *Glycolytic Ferment Theory*.—This is the theory of Cohnheim; he considers diabetes as depending upon "the absence of a ferment which in a normal condition initiates the further destruction of dextrose." This theory in an extended form has gained ground of late, especially since Mering and Minkowski broached the theory that the pancreas possesses an internal as well as an external secretion, and that it was the absence of the former, probably furnished by the cells of the islands of Langerhans,

which led to diabetes. This internal secretion Lepine looks upon as of the nature of a ferment, constituting the glycolytic ferment present in normal blood, and which may act either by influencing the production of sugar from glycogen or the production of glycogen from dextrose or the tissues themselves, so that (in health) they consume the dextrose. This leads us to the last of the principal theories.

(4) *Tissue Glycolytic Theory*.—This is supported by Epstein and von Noorden, who hold that in diabetes less sugar is consumed in the tissues. It does not mean that the oxidative processes in the tissues are less than in health, but that the patient, unable to use sugar for thermogenesis, breaks down proteid and fat for the purpose.

To sum up: "We cannot as yet formulate one theory to explain all morbid conditions in which sugar is discharged with the urine. Nor can we positively say whether that excretion of sugar depends upon an excessive formation or upon a diminished consumption, but the weight of evidence is in favour of the view that excessive quantities of sugar are produced, and it is generally held that the seat of that excessive production is the liver. There is evidence, however, which suggests forcibly that in phloridzin diabetes, in artificial pancreatic diabetes, and in diabetes mellitus the sugar may be of proteid origin, in which case the seat of formation would probably not be confined to the liver. Nevertheless, the possibility even in these diseases that the sugar is of carbohydrate origin cannot be excluded."<sup>1</sup>

We now come to the symptomatology of diabetes, and in such an assembly as this it would hardly be fair to waste your time over a long list of symptoms with which you are all perfectly familiar. We are unfortunately usually consulted only when glycosuria has become confirmed, but there are a number of premonitory symptoms which will often help to put one on the *qui vive*, and be beforehand with the diabetic condition. Of such are persistent insomnia, bilateral neuralgia, paroxysmal diarrhoea, emaciation, loss of physical power and mental activity, impotence,

<sup>1</sup> Lazarus-Barlow, "Manual of General or Experimental Pathology," Second Edition, 1904, p. 576.



fatigue of lower extremities, mental depression, furunculosis.

The four classical and well-known features of confirmed diabetes are polyuria, glycosuria, polydipsia and polyphagia.

One or two points in the urology of diabetics are well worth remembering. The first one is that the glycosuria is abundant and constant. The second that the quantity of urea contained in the urine is also excessive. Regular estimation of urea is of importance; for rapid emaciation may take place even in the obese if urea be excessive from breaking up of proteids.

In severe cases phosphates are also in excess. It is also worth referring here to the probability of the presence sooner or later of one of the so-called acetone bodies: these are acetone, diacetic acid,  $\beta$  oxybutyric acid and  $\beta$  crotonic acid; each of these has in turn been credited with being the cause of diabetic coma; at present diacetic acid holds the field.

In connection with urine testing by means of Fehling's solution, especially where the proportion of sugar is small, let me recommend the cold test, which consists in mixing in a test tube equal quantities of the urine and Fehling, and allowing the tube to stand in a cool place for twenty-four hours. If traces of glucose be present, the characteristic changes will take place, but such bodies as kreatine, kreatinine, &c., which reduce in a hot solution, have no effect in the cold.

That the prognosis in diabetes depends very largely on the condition of the urine goes without saying, and in addition to the question of sugar and urea excretion, we should before hazarding a prognosis satisfy ourselves that neither albumen nor any of the acetone bodies are present. A very moderate glycosuria with albumen present assumes a much graver significance, and the presence of acetone or its allies tells us we have to deal not only with confirmed diabetes, but that a catastrophe may be imminent.

In addition to the above, regard must be had to (1) hereditary antecedents; (2) to the state of the digestive functions—the more nearly normal these are the better the



outlook; (3) obesity—the obese or arthritic type of diabetes pursues a long course, and may last fifteen, twenty, or even thirty years; this is the *diabète gras* of French authors; (4) the opposite condition, which they consider as the pancreatic variety, and designate *diabète maigre*; this runs a much more acute course, especially in infants, as Dr. Bodman will tell us presently. In adult life its duration usually varies from twelve months to three years; but we may say decidedly that the younger the patient the more hopeless the outlook. The condition of the nervous reactions also affords considerable help in prognosis. Where the various reflexes are still present the outlook is distinctly more hopeful.

The treatment of diabetes resolves itself naturally into the dietetic and the medicinal. A very large majority of those who have written on the subject of diabetes of late years agree in recommending a restricted diet, except in very mild cases; but it must not be forgotten that if acetone or diacetic acid be already present in the urine a radical change of diet is dangerous, and also that if, in spite of rigid diet, sugar persists, a certain amount of bread should be added to the diet. In mild cases, after a month or two of restricted diet, we may test the patient's tolerance of starch, and act accordingly. Where starch has to be withheld altogether we have a host of articles brought forward during the last few years to take its place—almond bread, soya bread, peanuts, cocoanut bread, malt diastase, iceland moss, artichokes, lævulose, plasmon and its congeners, potatoes, and, latest of all, yolk of egg in large quantity.

In the way of organic remedies we have thyroidin, testiculin, pancreatic grafts, pancreatic juice.

The list of drugs given for diabetes during the last eight or ten years is certainly suggestive (some of them being not quite unknown to the followers of Hahnemann). They are: lactic acid, picric acid, antipyrin, kreosote, jambul, jaborandi, hydrogen peroxide, codeine, opium, ozonic ether, sodium arseniate, strontium bromide, uranium nitrate. A number of these we have most of us used, not empirically, however, but guided by the records of their physiological effects.

Looking through my own case-books, I find that the drugs I have used most persistently have been phosphoric acid, uranium nitricum, jambul, lycopodium, and codeia, and for acetonæmia, peroxide of hydrogen in the shape of ozonic ether. The other drugs of which the use is recorded in our literature are arsenicum album and arsenicum bromidum, helonias, kreosote, lycopus, natrum muriaticum and sulphuricum, and thuja, but of these I have had no experience.

I would like to say a few words upon the influence of alkaline waters. I have sent a few patients to Carlsbad, and have seen others who had already been there. The conclusion to which I have come is, that patients of the obese type do well at Carlsbad, but with those who are of the opposite type, and are losing flesh, no good but positive harm is done by a sojourn at Carlsbad. Other writers have found the same after the continued use of other alkaline waters.

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## A CASE OF ACUTE DIABETES MELLITUS, WITH SOME REMARKS ON THE DISEASE AS IT OCCURS IN CHILDREN.<sup>1</sup>

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Bristol.*

MR. PRESIDENT AND GENTLEMEN,—When honoured by the Secretary of this Section with a request for a paper for your consideration, it occurred to me that it might be of interest to give a few particulars of a case of diabetes mellitus, of unusually short duration, which had recently been under my observation.

P. S., aged 12, first came under my notice on October 27, 1904. It had been remarked that for the last two or three weeks the boy had not seemed well, but with the exception of his being very thirsty, and of his having become thinner, nothing particular had been observed.

<sup>1</sup> Presented to the Section of General Medicine and Pathology, April 6, 1905.

The family history showed that his father had died from gout, asthma, and bronchitis, and the mother from valvular heart disease.

On enquiry, it was elicited that the patient had vomited once the previous day, that his appetite was large, he complained at times of a pain in the left hypochondriac region, and passed an increased quantity of urine. The bowels were constipated. There was no antecedent history of illness, injury, or nervous shock.

On examination the tongue was found to be red and raw-looking, but no abnormal physical signs could be detected. Temperature 95°.

The urine was opalescent, of a greenish colour and sickly odour; specific gravity 1028; it contained a trace of albumin and 3·8 per cent. of sugar, giving also a well-marked reaction with perchloride of iron, indicating the presence of diacetic acid. Phosphoric acid 1x. was prescribed.

On the 29th the boy was much worse, being semi-comatose and delirious. He vomited once on the previous day and would take no food but milk, of which five pints were taken in the twenty-four hours. The pupils were of medium size, the breath had a sickly odour, the skin was dry and the body surface cold. The radial pulse could scarcely be felt, its rate being 68. One hundred and forty-four ounces of urine were passed in the eighteen hours ending at 10 o'clock that morning, of specific gravity 1033 and sugar 3·6 per cent.

An enema of hot saline solution was ordered but not retained.

Uranium nitrate 3x. was substituted for the phosphoric acid.

The next day the patient was completely comatose, with restlessness, cyanosis and great dyspnoea, the respirations being hurried and shallow (described as "air-hunger"). A much smaller quantity of urine had been passed since the previous morning, only about a pint, and none at all for several hours. An intravenous injection of a solution of sodium chloride and sodium bicarbonate was given, but the patient never rallied, and died comatose and without any convulsions.

An autopsy was performed the following day. Very little adipose tissue was to be found, the heart-muscle was pale and the wall of the right ventricle thin. The lungs were congested, but there were no evidences of tubercular infection. The stomach was dilated; a few enlarged mesenteric glands were found. The liver was considerably

enlarged and pale in colour. The pancreas appeared rather small and of tougher consistency than usual, but subsequent microscopical examination revealed no abnormality.

The cortex of the kidneys was swollen and pale, the capsule stripping easily, showing enlarged stellate veins on the surface. Nothing abnormal was found in the brain or meninges.

Thus it will be seen that that so rapid was the course of the disease, that death occurred only three days after the case came under treatment.

Diabetes mellitus is uncommon in early life, but it was stated two years ago that there were 500 cases reported in the literature.

#### ETIOLOGY.

*Age.*—No age is exempt from the disease, even nursing infants having been observed to suffer, but it is extremely rare under 2 years of age; thus, of 117 cases in children collected by Stern, six were under 1 year. The proportion of cases observed under 10 years of age is variously given as from 0·2 to 1 per cent., and between 10 and 20 as 3 to 7 per cent., while in thirteen years thirteen children under 5 died from diabetes mellitus in New York City.

The occurrence of the disease in intrauterine life has been inferred from the presence of sugar in the liquor amnii in two recorded cases, but this has not yet been proved to take place. The frequency of the affection rapidly increases after puberty.

*Sex.*—Males and females are about equally affected up to 10 years of age; from 10 to 15 females are more frequently attacked, while, after this, males predominate more and more as age advances.

In 1889, out of 1,754 fatal cases of diabetes mellitus in England, the sexes were affected as follows:—

			Males.			Females.
Under 5	...	...	9	...	...	5
5 to 10	...	...	11	...	...	11
10 to 15	...	...	19	...	...	28

*Heredity* is generally conceded to have an important etiological influence, and, in considering this question, it is necessary to take account of uncles, aunts and cousins, as well as more direct ancestors. Trousseau says that children of tuberculous parents are particularly susceptible to diabetes. Gout, syphilis, insanity, nervous diseases and obesity, seem to have a hereditary predisposing effect. Several children of the same family are sometimes affected.

*Nervous shock* appears to bear a causative relation in some cases. Thus, Pitchford reports a case of diabetes in a boy of 9, in whom symptoms first appeared eighteen days after the death of his mother (from phthisis), the patient's death following in three weeks, though he was playing about six days before the fatal issue. Teschemacher also mentions an interesting case in a boy of 7, whose aunt died from diabetes. The urine when first examined contained 4 per cent. of sugar, but under diet and treatment gradually disappeared. He was frightened by a dog, and the next day there was 3·3 per cent. of sugar, which, eight days later, again disappeared.

Diabetes not infrequently follows one of the acute infectious fevers. Injury to the head and eating an excessive amount of sugar are also supposed to have an etiological bearing.

#### PATHOLOGY.

The anatomical features are similar to those seen in adult cases. The liver is enlarged and fatty; the kidneys usually show evidence of diffuse nephritis, with fatty changes. Lesions of the pancreas occur in about half of the cases, usually a general atrophy of the organ. Tumours of the medulla oblongata have been found. Tuberculosis of the lungs is relatively uncommon, but pneumonia is prone to occur.

What is the cause of the rapid course of the disease in the young? It may be that the child possesses a smaller store of alkaline salts with which to neutralise the acid intoxication, which is so marked a feature of the disease.

Or it may be connected with the activity of the thyroid, and other glands producing an internal secretion, in childhood. This would seem to be the case from the facts mentioned by Dr. Arnold Lorand at a recent meeting of the Pathological Society.

He notes the similarity in structure between the islands of Langerhans in the pancreas to that of the parathyroid glands, the medullary portion of the suprarenals and the interstitial cells of the testicle, and states that extirpation of the thyroid is followed by an increase in the number of the islands of Langerhans, while glycosuria disappears, in diabetic dogs, after the removal of the thyroid gland. Thus, with atrophy of the pancreas in the aged, the glycosuria is slight, but, when the pancreatic changes are associated with very active thyroid changes, as in young people, the glycosuria is likely to be very severe.

#### COURSE AND DURATION.

Diabetes mellitus runs a much more rapid course in children than in adults, the younger the patient the more rapid the course of the disease. It is usually fatal in from two to four months after symptoms become marked ; very few live more than six months, though occasionally it may last one or two years. A case has been reported in an infant in which death took place only two days after the symptoms were first observed. In 117 cases collected by Stern, seven died within a month of the onset of the disease.

In young children the onset is usually abrupt and the course acute, the former frequently following some psychical disturbance or bodily injury, with a well-marked family history of diabetes or other constitutional disease. In the second decade of life the disease is often latent, suddenly assuming a rapid course, though the patient may appear to be in his usual health at the time. The majority of cases terminate in coma, this being a particularly frequent ending in children.

#### SYMPTOMS.

The special peculiarities of diabetes mellitus in children are, the large amount of sugar, and small quantity of urea

excreted; the great rapidity of the course of the disease and its frequently fatal ending, in the majority of cases by coma; the infrequency of tuberculosis as a complication, and the occurrence of œdema of the eyelids and extremities. The chief symptoms are: rapid and pronounced emaciation, dryness of the skin and mucous membranes, restlessness and irritability, constipation, thirst, polyuria and irritation of the external genitals. The appetite is sometimes increased, but it may be poor. Incontinence of urine is of common occurrence and is frequently the first symptom for which medical advice is sought. The lymphatic glands may be swollen, hard and painless, probably in connection with one of the cutaneous lesions which often complicate this disease, though the tubercle bacillus may play a part in their enlargement.

The *urine* is greatly increased in quantity, averaging from five to eight pints daily, but may reach double that amount, or may even be less than normal. The specific gravity is high, 1026 to 1040; sugar is present in varying quantity, ranging from a trace to 8 or 10 per cent., but rarely more than this. There may be slight albuminuria with the presence of a few casts, but this does not necessarily signify more than a mild renal hyperæmia. The sugar may disappear from the urine for a time, under appropriate diet and treatment, but the polyuria and emaciation continue.

Acetone and diacetic acid are found in the urine in advanced cases and are always of serious moment. Their presence indicates that the blood and tissues are overladen with acids, and the quantity present is of prognostic import as regards the occurrence of coma; though they may be found in the urine months before any signs of coma and may even disappear again without coma supervening. Death may be due to coma, or progressive wasting, or may result from pneumonia or tuberculosis. Coma may supervene suddenly, or may follow an acute catarrhal enteritis; every acute catarrh of the intestines being of serious moment in the course of diabetes; more frequently, after a period of restlessness, the child becomes drowsy, complains of epigastric pain, with nausea, vomiting and obstinate constipation; the respiration becomes shallow and hurried, cyanosis develops,



the odour of acetone can be detected in the breath, and the coma deepens and passes into death.

*Complications* similar to those seen in adults occur, though œdema is more common and is not always dependent on disease of the heart or kidneys. Otitis media and inflammation of the mastoid cells may suddenly develop.

#### DIAGNOSIS.

*Diagnosis* from merely temporary glycosuria may be aided by the fact that in the latter affection, the urine is generally free from sugar in the early morning, but after taking food a considerable quantity is present. A carbohydrate-free diet will also put a stop to the excretion of sugar. Convulsions are rare in diabetic coma and this will assist to differentiate from uræmia, for albuminuria may be present at the termination of diabetes. Nocturnal incontinence of urine with wasting should always arouse suspicion.

#### PROGNOSIS.

Recovery is rare and diabetes in children is considered by some to be hopeless and treatment of no avail, though by others the proportion of recoveries is variously given as 5, 18 or 36 per cent., the discrepancy being probably due to the inclusion of cases of temporary glycosuria in the more favourable statistics. The presence of diacetic and oxybutyric acids is of worse prognostic import than a high percentage of sugar, and, if found in the urine, the patient is not likely to live more than three months.

#### TREATMENT.

Treatment should be on similar lines to that of adult patients.

*Dietetic.*—A strict carbohydrate-free diet should be advised, and is usually well borne by children, though the individual capacity for assimilating sugar should be tested from time to time and the case dieted accordingly, but carbohydrates must be allowed with greater caution than to adults.



Opinions differ as to the permissibility of more than a small quantity of milk, but a pint slowly sipped morning and evening may generally be allowed. If sugar-free milk can be obtained, it is of great service to the patient. An excess of meat in the dietary is said to cause an increase in the amount of sugar excreted, and a German authority gives it as his opinion that in children the withdrawal of carbohydrate food is useless and harmful, in that the excreted sugar is taken from the body proteids and the quantity in the urine remains the same. He would reduce the amount of bread taken to a minimum and allow a diet of meat, vegetables and potatoes.

*Hygienic.*—Gentle exercise or massage is of service, for muscular exercise frequently reduces the glycosuria, especially in recent cases and when the nutrition is well maintained; in older cases and greatly emaciated individuals it may, however, increase the amount of sugar excreted. When coma threatens, large quantities of milk and other fluids should be given, and a little carbohydrate food may be allowed as a temporary measure. In actual coma, the intravenous injection of a 3 per cent. solution of sodium bicarbonate is advised, but von Noorden states that he has never seen more than temporary benefit from its use, and, as in the case detailed above, it may not produce any amelioration.

*Prophylactic.*—In the case of marked hereditary predisposition to diabetes, a quiet and regular life, with outdoor exercise in moderation, and the early and permanent withholding of carbohydrate food, especially sugar, may prevent the incidence of the disease.

Great care should be taken to prevent the young patient taking cold, or any zymotic disease, as the supervention of bronchitis, whooping cough, or scarlet fever, would have most serious consequences.

Medicinal treatment of diabetes mellitus occurring in children is, of course, similar to that of the disease in adults. I have, therefore, nothing to add under this heading to the valuable information already presented by my distinguished predecessor.

A CLINICAL STUDY OF SOME DISEASES OF THE PANCREAS.<sup>1</sup>

BY FRANK A. WATKINS, M.R.C.S., L.R.C.P., L.S.A.

*Pathologist to the London Homœopathic Hospital.*

DURING the last twelve months five cases of pancreatic disease have passed through the wards of this hospital; and as wishes have been expressed that one of them at least should be published, I have ventured to bring them before the notice of this Society in the hopes that they will not be found altogether uninteresting and of some practical value.

*Case 1.*—As there was nothing of much interest in this case, I do not intend to give the details, save to mention that the patient was suffering from general tuberculosis, which probably originated in the genito-urinary tract. When the *post-mortem* examination was made, it was found that there were numerous patches of fat necrosis distributed throughout the peritoneum. The pancreas, on macroscopic examination, appeared to be normal, but, unfortunately, no microscopic section was made. A section of the necrosed fat is laid on the table for your inspection.

*Case 2.*—J. J., housekeeper, aged 58 years, was admitted into the London Homœopathic Hospital, under the care of Dr. Washington Epps, on March 21, 1904, but had been an out-patient under the care of Dr. Stonham since the previous August, suffering from jaundice. Patient thought the jaundice was due to sleeping on a damp bed; says that the day after she noticed her urine change colour, and this was followed within fourteen days by general jaundice.

Previous history good, with the exception of attacks of "congestion of the chest," which sometimes laid her up. Climacteric was reached at age of 50. Says she has been losing flesh lately.

*Present Condition.*—Complains of no abdominal pain. Marked œdema of legs up to the knees. Loose white stools, dark urine, tongue rough. Chest feels tight, harsh respirations all over the chest. Jaundice is present. Abdomen is distended, and contains some free fluid.

<sup>1</sup> Presented to the Section of General Medicine and Pathology, April 6, 1905. •

March 23.—Complains this morning of sharp hepatic pain extending to the right shoulder, also of "wind" in the abdomen, which is tensely distended, so that the contents cannot be now palpated. Urine contains a little bile.

March 25.—Examination *per rectum* revealed ballooning of the rectum and retroversion and retroflexion of the uterus. Considerable tenderness of the uterus on manipulation.

April 20.—Pain continues in the hepatic region and over right shoulder. Has gained  $4\frac{1}{2}$  lbs. in last fourteen days. Jaundice is rather more marked.

April 21.—Asthmatic râles all over the chest. Gurgling and bubbling sounds of fluid over back of right lung at base. Vocal resonance is also diminished. Œdema of the back as high as the tenth dorsal spine, also of the abdominal walls and legs. A consultation was called, and it was thought that patient was suffering from malignant disease of the liver.

April 30.—Abdomen tapped yesterday, and  $9\frac{3}{4}$  pints of bile-stained transparent fluid were drawn off. This morning peritoneum seems about full as before; the œdema of the legs has been much relieved.

May 2.—Paracentesis abdominis again performed yesterday, and 9 pints 18 ounces of fluid withdrawn. There is no enlargement of the liver to be made out by palpation and percussion. The signs of fluid at base of right pleura are still present.

May 5.—Patient became more feeble each day and died on May 12.

*Post-mortem* examination was made on May 12 by Dr. Frank A. Watkins, pathologist to the hospital.

Both pleuræ contained a small quantity of bile-stained fluid, and a small amount of lymph was present on the visceral pleuræ.

Both lungs were much congested, especially the bases.

The pericardium contained a small quantity of fluid, and there was some lymph on the visceral pericardium.

The heart was pale and very flabby; aortic and mitral valves were atheromatous.

Abdomen.—There was very little omental fat present. The peritoneum contained an enormous quantity of bile-stained serum. The liver was markedly cirrhotic, its surface presenting a hob-nailed appearance, and its consistence was exceedingly tough. There was evidence of recent hepatitis on its upper surface; there were dense adhesions around the gall-bladder and transverse fissure, the former being so compressed that it contained only a very small quantity of bile. Weight, 38 ounces.

Spleen weighed  $8\frac{3}{4}$  ounces.

Kidneys.—Both intensely congested; capsules stripped with difficulty.

Pancreas.—Weight, 6 ounces, and showed slight evidence of hæmorrhages.

#### MICROSCOPIC REPORT.

Section No. 469 taken from pancreas.—This shows the presence of a considerable round-celled infiltration of the glandular tissue. There are small hæmorrhages present in the fibrous septa between the lobes of the pancreas.

The autopsy showed that the disease of the liver was not due to a malignant growth, but that it was due to cirrhosis, and also revealed the presence of hæmorrhagic pancreatitis and enlargement of the spleen. It is not an uncommon occurrence to find pancreatitis associated with cirrhosis of the liver; more especially in those cases described as “diabetic bronzing.” I have drawn attention elsewhere that this association seems to throw light on the etiology of pancreatitis. The cirrhosis of the liver occurs first—being the result of absorption of toxins from the portal circulation; when the functions of the liver fail the toxins enter the general circulation and then ensues the pancreatitis.

*Case 3.*—I am indebted to Dr. Hall, of Surbiton, for his kind courtesy in furnishing notes of this case prior to her admission to the hospital.

“The patient, C. M., came to me at the dispensary complaining of dyspeptic symptoms, but, as I had not the time there to examine her carefully, I suggested seeing her at home in bed. On December 6, 1904, I paid my first visit and examined her carefully. She complained only of sickness, and vomited all food; the matters brought up were mostly fluid and of a dark green colour, and at times were very copious; the only pain complained of was under the right scapula posteriorly. Nothing was found in the lungs or heart. Upon inspecting the abdomen, there was apparently no distension and no abdominal swelling in any part. Upon palpation, there seemed some dilatation of the stomach; and the liver dulness appeared to be very small, but there was no general tympanites and no evidence of free fluid in the abdominal cavity. No pain or tenderness was elicited in any part of the abdomen after most careful palpation. Bowels were some-

what constipated, but were moved by enema or mild purgatives, and the motions were of the normal colour. There were no pelvic symptoms, and examination *per rectum* revealed nothing. I saw her almost daily until the 29th, and during this time the sickness gradually increased so that nothing could be retained upon the stomach; the tongue also became dry and brown, and the pulse quick and feeble. Rectal feeding was resorted to, and the vomiting was controlled to some extent, but still continued. On the 29th inst. Dr. Johnstone saw the patient with me, and made a careful examination, but could not find anything definite; he suggested there might be obstruction of some kind, and advised her removal to hospital, as an operation might be rendered necessary; she was accordingly carefully removed and placed under the care of Dr. Byres Moir. I may say that from the symptoms I looked upon the case as one of liver trouble, and treated it accordingly, but later on was very much puzzled and could not decide exactly what was the pathological condition; the urine was examined from time to time, but nothing abnormal was found. None of the remedies used had any effect in checking the vomiting; only the rectal feeding seemed to control this in any way."

The patient was removed to Durning Ward of the London Homœopathic Hospital, under the care of Mr. Knox Shaw, on December 30, 1904. The following clinical notes were made by Dr. A. Taylor, the house physician.

*History of the present illness.*—Since June, 1904, has complained of pain and distension of abdomen. Five to six weeks ago began to vomit; this, later on, became of a pumping character, and amounted to about one and a half pints at a time; the colour was a dark green, with a sediment at the bottom. Two or three days before admission the vomit was said to be black, like clotted phlegm. Micturition became difficult whilst in the recumbent position, and, consequently, patient was obliged to sit up, when she would pass about a teacupful of urine at a time.

*Past history.*—No previous illness, always strong. Has eight children living. Temperate habits.

*Present condition.*—Lies in a semi-dozing condition; has a deep red flush over the face; tongue dry, fissured, brownish-white fur; answers questions rationally. Urine contains slight cloud of albumen, somewhat turbid, amber colour.

*Abdomen.*—Walls very thick, doughy, and flabby. Nothing abnormal felt on palpation. Very little dulness over the liver area; some tenderness in the mammary line. Nothing abnormal detected with the spleen.

On January 2, 1905, patient was transferred to Quin Ward under the care of Dr. Byres Moir.

January 3.—Vomited once yesterday. Nutrient enemata were tried, but were not retained, so patient was fed by the mouth with Valentine mixed with hot water. Two hypodermic injections of  $\frac{1}{80}$  grain of strychnia were given during the day.

January 4.—All enemata are returned. Vomited twice yesterday. Now in a cold sweat; pulse almost imperceptible. Temperature at 12 p.m. yesterday,  $96.8^{\circ}$ ; this morning at 8 a.m.,  $100.4^{\circ}$ . Patient died at 2 p.m.

*Post-mortem* examination was made on January 5 by Dr. Frank A. Watkins. Excessive amount of adipose tissue everywhere. Both pleuræ were adherent; no serous fluid in the cavities. Venous congestion very marked in both lungs. The pericardium was normal. The myocardium was pale and flabby, but did not contain much adipose tissue; the valves appeared to be normal.

Stomach.—Enormously dilated; the mucous membrane presented evidence of gastritis, with petechial hæmorrhages, and there was a small superficial ulcer near the pyloric orifice.

Intestines.—The first part of the duodenum was enormously dilated, and appeared to be a part of the stomach, so that the pyloric sphincter was quite obliterated. The second part of the duodenum was much contracted, and its lumen allowed only of the passage of a little finger, the obstruction being caused by the pressure of the enlarged head of the pancreas, which was encircling the bowel in two-thirds of its circumference.

The wall of the duodenum was not infiltrated with growth apparently. The remainder of the small intestine appeared normal. The large bowel was nearly empty and collapsed.

The appendix vermiformis appeared healthy.

No peritonitis was present. No fat necrosis.

Liver.—Weight,  $46\frac{1}{2}$  ounces; presented a nutmeg appearance, and some yellowish patches were present on its upper surface, and extended for some little distance into its substance; this was probably due to fatty degeneration. No evidence of cirrhosis was present. The gall-bladder was greatly distended with bile, owing, probably, to pressure on the common bile duct at the back of the head of the pancreas. A very small gray-white nodule, about the size of a mustard seed, was observed on the under-surface of the liver, and removed for microscopic investigation.

Pancreas.—The head was much enlarged and very hard and tough, and enveloped the second part of the duodenum in two-

thirds of its circumference. The tissues here were matted together, and the mesenteric fat seemed to be infiltrated with the growth in the pancreas.

Spleen.—Normal.

Kidneys.—Both showed the presence of venous congestion; the capsules stripped fairly easily.

#### MICROSCOPIC REPORT.

Section No. 551 taken from head of the pancreas.—There is no normal glandular tissue in this section, but it has been replaced by a carcinomatous growth, chiefly of an encephaloid type, in which the alveoli are filled with cubical or spherical cells. In the centre of the section are some tubules lined with one or more layers of columnar cells.

Section No. 552 taken from under-surface of the liver.—The liver tissue is intensely congested all around the nodule, and the hepatic cells are in a state of advanced fatty degeneration; in places are some granules of dark brown pigment. The nodule consists of a tubular carcinoma, in which some of the tubes are lined with columnar cells, others with cubical or spherical cells.

Section No. 552A taken from another part of the liver distant from the nodule.—This is not nearly so much congested.

A specimen of urine which was forty-eight hours old was examined on the day of the *post-mortem* examination for Cammidge's pancreatic crystals, but none were found in either tube.

From the autopsy it is evident that the primary cause of death was the carcinoma of the pancreas.

It will have been noted that prior to death there were present no signs or symptoms which would lead one to suspect cancer of the pancreas; in fact, the only pathological condition diagnosed was the dilatation of the stomach which was revealed to Dr. Hall, on palpation of that organ, and confirmed in the hospital by the "pumping" character of the vomiting; and Mr. Johnstone suspected the intestinal obstruction. When the growth in the pancreas spreads in an upward and forward direction, as in this case, it usually causes jaundice by pressure on the common bile duct, as well as the pyloric obstruction with consequent gastric dilatation; and when they are both present there would not be



much difficulty in arriving at a correct diagnosis. If this patient had lived a little longer no doubt the jaundice would have supervened, for the gall-bladder was already greatly distended.

Is there any other method of examination by which we may determine the presence of disease of the pancreas? Mr. Mayo Robson, in conjunction with Dr. Cammidge, believes that there is. In the Hunterian and Harris and Gale lectures, delivered at the Royal College of Surgeons last year, they made their most interesting communications; they maintain that by treating the urines of such patients chemically a reaction is obtained whereby it is possible to determine not only whether pancreatic disease is present but also the nature of it, that is, whether it is due to a malignant growth or acute or chronic inflammation, and if glycosuria is present, whether this is of pancreatic origin or not. They base their conclusions on the investigations of 300 specimens of urine; during the latter part of their researches the urines from patients suffering from suspected pancreatic disease were sent to the laboratory for examination without any indication as to the nature of the report expected, and thus any unconscious bias was avoided, and a true estimate of the reliability of the tests was formed. Reactions pointing to pancreatic disease were obtained in 111 cases, and the diagnosis in every case was confirmed on operation.

The specific reaction appears to be due to the presence of glycerine in the urine, which has been liberated from the fats of the body by the influence of the pancreatic juice. By treating this urine with certain chemicals crystals are precipitated having a similar appearance to those of phenyl maltosazone, but somewhat finer; they are of a golden-yellow colour, needle-shaped, and arranged in sheaves or rosettes. The process is a lengthy one, and takes about an hour to carry out; the crystals are precipitated during the following twelve to twenty-four hours, and then their solubility in dilute sulphuric acid must be tested. The process fully described will be found in the *Lancet* of March 19, 1904. It must be carried out with the most



scrupulous care, otherwise somewhat similar crystals will appear and the results vitiated.

It will have been noted that I applied the test to the urine obtained from the above case of pancreatic carcinoma with a negative result; but I think that was due to the fact that the urine at the time was in a state of decomposition, and had been obtained from the patient whilst in a moribund condition.

Since then I have examined the urines from two cases of suspected pancreatic disease, and in each case obtained positive results.

The following is an extract of the clinical notes of one of these patients, made by Dr. A. Taylor, house physician:—

*Case 4.*—F. P., aged 38, female, admitted into the London Homœopathic Hospital on October 4, 1904, under the care of Dr. Galley Blackley.

Seven years ago began to be troubled with pain in the stomach after food, and later on it also occurred during the night, compelling her to get up and walk the room; felt sick at times, but never vomited. Three months ago noticed herself become yellow, and a month later clear water used to come up into her mouth during the night. Has not been able to work for some time, as movement makes her feel sick. Has avoided vegetables and fruit for the last three months, as she could not digest them. Says she has been losing flesh since the appearance of the jaundice.

*Present Condition.*—Has been free from stomach pain now for two months, but there is some aching in the right loin. The urine has been thick and green since the appearance of jaundice. Bowels regular, motions are the colour of putty, appetite very good, tongue dry and furred, sleep very broken, catamenia have been irregular for last two months, temperature varies from 98° to 100·2° F., patient is deeply jaundiced all over. Weight on admission, 5 st. 9 lb.; says she used to weigh about 7 st. before the jaundice. Liver projected below the costal margin for a distance of three fingers'-breadth.

October 20.—A specimen of urine was treated yesterday by Dr. Watkins according to Cammidge's test for pancreatic crystals, but none were found. Microscopic examination of the fæces did not show any excess of fat globules, but abounded in fine needle-shaped crystals, which are probably fatty acid crystals.

October 24.—Weight, 5 st. 5½ lbs. Symptoms and condition remain much the same. To-day a consultation was called, and there was a good deal of difference of opinion as to the condition of the liver; the majority thought malignant disease of the liver was present, others that the jaundice might be due to unilobular cirrhosis or blocking of the common bile duct by gall-stones. It was agreed to put the patient on chel. 1x.

November 21.—Weight, 5 st. 7½ lbs. Motions are more gray in colour.

December 12.—Another consultation was called to-day, but no agreement as to the condition was arrived at. It was decided to postpone any exploratory operation for the present. Protiod of mercury 3x. was prescribed.

February 6.—Weight, 5 st. 10¾ lbs. Condition much the same. At a consultation held to-day an exploratory operation was advised.

Cambridge's test was again applied to a sample of urine by Dr. Watkins, the bile pigment being first removed, and a search made for glucose and albumen. After twenty-four hours in A tube there was a heavy deposit of golden-yellow crystals arranged in rosettes. No crystals in B tube. The crystals, when exposed to a 33 per cent. solution of sulphuric acid, dissolved in thirty-five seconds. According to Cambridge, this would indicate that an exploratory operation is advisable, and that pancreatitis is present in an acute form.

February 14.—Patient was anæsthetised and Mr. Dudley Wright made an angular incision about eight inches long below the costal margin. It was then found that the liver was not enlarged, was very dark in colour, and showed signs of old localised hepatitis. The abdominal cavity contained a large quantity of serous fluid, somewhat bile-stained. The stomach and colon were adherent to under-surface of the liver. The gall-bladder could not be found on account of adhesions of other structures, which entirely shut it out from the peritoneal cavity. In the position of the head of the pancreas was a hard mass, and from this an extension upwards was felt to the region of the transverse fissure, where another large hard mass was present. Several enlarged mesenteric glands were noticed. The wound was immediately closed, and it rapidly healed, and patient was discharged on March 1.

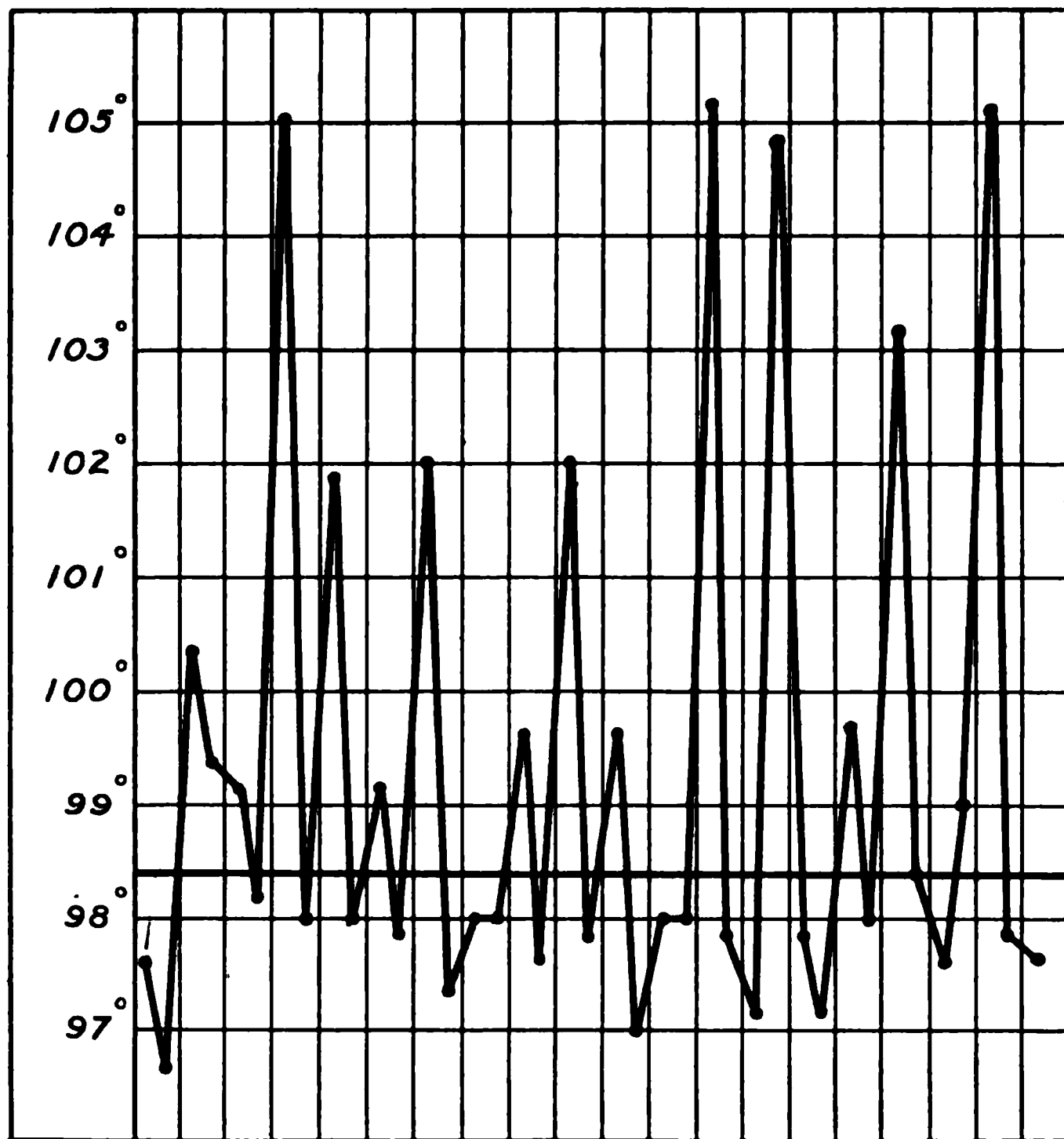
February 25.—Dr. Watkins made another examination of the urine, but obtained no crystals in either tube. The urine contained very much less bile pigment.

It is much to be regretted that, owing to the extensive adhesions, the pathological condition could not be more definitely defined, but there can be little doubt that the patient was suffering either from cancer of the pancreas or a growth in its immediate neighbourhood, which was obstructing the common bile and pancreatic ducts. The results obtained by examination of the urine would indicate that the latter was the true explanation, and, the pressure being intermittent, the reaction was not obtained constantly.

From a diagnostic point of view, this case was of a most puzzling character. At first the opinion leaned to cancer of the liver, but, when the supposed nodules on its surface could no longer be felt, and the patient was gaining weight, this view had to be abandoned (the operation revealed that some of the increase in weight could be accounted for by the occurrence of ascites). Subsequently an exploratory operation was recommended with the expectation that the jaundice was due to gall-stone obstruction. It may be of interest here to consider what signs and symptoms should have been present to confirm this view. Until quite recently it was taught that the gall-bladder would be found enlarged, but most surgeons now concede that Courvoisier's law is a true one, and which declares that there is no distension of the gall-bladder, but that, on the contrary, it is contracted; in many cases it is so deeply placed as to be quite out of the reach of the finger until the abdomen is opened. When this viscus is dilated it is due to quite other causes.

There is usually a rise of temperature attended by an ague-like attack. Murphy says: "The temperature rises to  $104^{\circ}$  or  $105^{\circ}$  within an hour, remains stationary for a few hours, and then drops suddenly to normal, and remains normal for hours, days, or even weeks, when it will go through the same rapid variation, and continue to repeat itself at irregular intervals." "These temperature changes are so characteristic that I have given them the name of temperature angle of cholangic infection."

Here is a copy of one of Moynihan's charts; he calls them "steeple charts."



MOYNIHAN'S STEEPLE CHART.

The pain is agonising, and radiates towards the right scapula, but never towards the pubes. Vomiting is the most frequent reflex. The position of the stone determines whether jaundice is present or not. In passing, I might mention that the most delicate test for the presence of jaundice is to withdraw into a capillary tube a few drops of blood from the patient; if bile pigment be present it will at once be obvious.

Besides these characteristic symptoms of gall-stone cholangitis, there are two tests which can readily be applied and the reactions are as constant as McBurney's tender point in appendicitis, and generally they can be elicited weeks after an attack of biliary colic. The first was introduced by Mayo Robson: "Draw a line from the tip of the

ninth right rib to the umbilicus; pressure with the tip of finger along this line will reveal a tender spot, usually situated about one inch above and one inch to the right of the umbilicus."

The second test is described by Murphy as follows: "The operator places the patient in a sitting position, with his back to the examiner. The trunk is flexed, the patient's hands resting on his knees. The examiner, sitting behind, places both hands around the patient's abdomen, all clothing having been removed, so that the points of his fingers are directed towards the middle line. The thumbs are uppermost. He then grasps the upper abdomen below the costal arch, whilst the patient is instructed to breathe deeply. With each expiration the hands sink more and more deeply, the left below the spleen, the right below the liver. As the right hand approximates the tender gall-bladder, tenderness is felt and the breathing becomes more difficult.

"When the right hand comes in contact with the viscus sought for, the breathing is suddenly stopped and very often a cry is elicited. It is not necessary for the hand to reach the gall-bladder for the manoeuvre to succeed; as soon as pressure comes to bear upon the tender mucous membrane, backed as it is by the resistant calculus, the arrest of respiration takes place. When there is no such backing, as in those cases where only adhesion or kinking of the bile duct is present, respiration goes on as before."

It is said that the X-rays will differentiate between biliary and pancreatic calculi.

*Case 5.*—S. H., female, aged 61, admitted into the London Homœopathic Hospital, under the care of Dr. Washington Epps, on February 8, 1905. Patient has had no previous serious illness. During last June had an attack of vomiting, which lasted about a week, but none since. Six months ago had some difficulty in walking for ten days, when she was given some medicine at a nerve hospital, which patient thought brought on the present illness, which began three months ago. Since then she complained of pain in the lower part of the abdomen, and says that food seemed to rest in the epigastrium as if it could not pass downwards. She first noticed herself yellow about six weeks ago, and the motions of a clay colour and white for two months.

No hæmorrhage. Has had poor appetite, and losing flesh for three months.

*Present condition.*—Skin: deep yellow colour. Liver: enlarged, vertical measurement  $5\frac{3}{4}$  inches; edge not felt; muscles very resistant. Stomach: slight splashing elicited. Urine: brown colour, acid reaction, specific gravity 1018; no albumen; no sugar; green reaction on addition of nitric acid.

February 15.—After the bowels had been relieved with soap and water enemata the surface of the liver was felt to be quite smooth and the edge regular. Weight, 6 st.  $13\frac{1}{2}$  lbs.

February 23.—Cambridge's test was applied to a sample of urine by Dr. Watkins, and a few very fine crystals were obtained in A tube, but none in B tube.

February 25.—Dr. Watkins again applied Cambridge's test and obtained a copious deposit of crystals in A tube and a few in B tube, but none in C tube.

March 16.—Coffee-ground vomit, which reacted to guiacum, but on microscopic examination no blood cells were found, and the Prussian blue test for blood also failed. Weight, 7 st.  $3\frac{1}{2}$  lbs.

March 21.—Coffee-ground vomit continues, but was much relieved by ipecac. 3x. At a consultation to-day it was agreed that the patient was suffering from carcinoma of the abdomen.

March 23.—Patient died to-day.

*Post-mortem* examination was made by Dr. Frank Watkins on March 24. Permission to open the abdomen only was obtained.

Stomach.—Some dilatation of the stomach was present; the mucous membrane showed the presence of gastritis, with petechial patches in places.

Intestine.—A new growth the size a hazel-nut was found in the mesentery of the small intestine; the mucous lining of the duodenum was ulcerated. The hepatic flexure of the colon was adherent to the gall-bladder and under-surface of the liver. There were numerous new growths—the size of filberts—affecting the appendices epiploicæ of the sigmoid flexure; and a larger one about the size of a walnut in the great omentum; all of these secondary growths contained small hæmorrhages. The transverse and descending colon were filled with hard scybala, and there were also a few in the ascending colon; here they were flattened and marked by ridges, which suggested they had been marked by the valvulæ conniventes during their passage through the small intestine. The omentum contained much fat.

Peritoneum.—The peritoneum contained much bile-stained, turbid serum; this lay free in the cavity, and was not loculated.

Behind the peritoneum were numerous small hæmorrhages, but no appearance of fat necrosis anywhere.

**Liver.**—The liver was large, smooth on the surface, bile-stained, and appeared to be of normal consistence. The surface was marked with patches of hepatitis, and one small nodule the size of a pea was observed on the upper surface and removed for microscopic examination. The gall-bladder was very much enlarged but almost empty; there was no communication with the cystic duct; the latter was much dilated and filled with dark brown fluid. No gall-stones were present.

**Spleen.**—The spleen was normal.

**Pancreas.**—The pancreas was invaded by a hard new growth as large as a cricket ball; on section it was of a yellow colour, thickly interspersed with small hæmorrhages.

**Kidneys.**—The kidneys were somewhat larger than normal and bile stained. The capsules stripped readily, leaving a smooth surface. Several small cysts were present in each kidney.

#### *Microscopic Report.*

Section No. 593, taken from the tail of the pancreas.—This is a schirrous carcinoma, the cells being more or less spherical.

Section No. 594, taken from the head of the pancreas.—This is also a schirrus, but shows active growth in places, and here the cancer cells are mixed up with red blood cells, which would indicate recent hæmorrhages.

Section No. 595, taken from the omental tumour.—This is a carcinoma of a schirrous type invading adipose tissue; hæmorrhages have also occurred here.

Section No. 596, taken from nodule in liver.—Similar cancer cells are infiltrating the liver tissue; little or no fibrous stroma is present. The capillaries in the neighbourhood of the nodule are intensely congested, and the liver cells are pigmented and fatty.

A notable feature in Cases 3 and 5 is the presence of hæmorrhages in all the new growths, with the exception of the nodules in the livers, where the surrounding tissues are acutely congested in both cases. I do not think that the condition can be fully explained by the disintegration to which malignant growths are liable; the occurrence of hæmorrhages in a schirrous cancer is not frequently observed, and in the latter of the two cases they are constant in all the growths. Another factor must be sought for, and it has



occurred to me that it may be due to the auto-destructive effects of the secretion from the cancerous pancreatic cells which is poured into the surrounding tissues and either dissolves the walls of the blood-vessels, which results in hæmorrhages, or it causes so much irritation that it produces the intense congestion as seen in the livers. If this be the true explanation, it would, in a measure, clear up the etiology of pancreatic hæmorrhage in general. It is only under physiological conditions that the pancreatic juice is unirritating to the organism; under pathological circumstances it produces destructive effects, for example, as is seen after contusion of the pancreas from traumatism, or where a surgical wound becomes infected with pancreatic juice, or where regurgitation of bile into the pancreatic duct occurs as the result of the lodgment of a gall-stone in the ampulla of Vater. Experimentally, hæmorrhagic pancreatitis has been produced by the injection of bile, bacteria, acids, and alkalies, into the pancreatic duct.

So far as I know, we have no explanation why, under normal circumstances, the pancreatic juice causes no destructive effects. In the case of the stomach it used to be thought that the peptonising effect of the juice on the gastric tissues was negatived by the circulation of the alkalies in the blood, but this argument could not be maintained when it was pointed out that the pancreas does not digest itself, its ferment being effective in an alkaline solution. It is evident that the gastric and pancreatic cells are endowed with vital functions which resist the action of proteolytic ferments, and such an explanation is not to be refuted by such experimenters as Cl. Bernard, who digested the leg of a living frog by placing it into a gastric fistula of a living dog, or as Pavy, who digested a large part of a rabbit's ear in a few hours by placing it in a similar environment. To sum up, it would appear that anything which disturbs the vital function of the pancreatic cells may be followed by hæmorrhage and other destructive effects.

Before bringing my paper to a close, I should like to draw a few practical conclusions.

During their clinical course there was some reason for



supposing that three of these patients were suffering from carcinoma, and yet the weekly record showed an increase of weight, instead of the usual steady decline; this, of course, would have been very misleading had it been inferred that it meant an increase of flesh; in all of these cases it was due to the occurrence of ascites.

It is unsafe to diagnose primary cancer of the liver unless one can feel with certainty the nodes, nor is an undue prominence of one lobe sufficient, for, as in Case 5, this may be due to a large tumour of the pancreas pushing it forwards. Primary cancer of the liver is a rare disease, and before it far advanced the tumours can be almost always readily felt. If jaundice is present without an obvious cause in a patient who has reached middle life, and no nodes can be felt in the liver, some other cause must be sought for.

It is early yet to generalise as to the importance of Cammidge's crystals. He says he has found them in cases of adenitis, pneumonia, and cancer of other organs than the pancreas. I have found them in both reactions in two samples of urine which contained heavy deposits of uric acid crystals, so that it would appear from the evidence before us that their occurrence indicates the presence of some serious error of metabolism, and when the reaction is obtained in No. A tube only, it may possibly mean that the metabolic disturbance is specifically due to disease of the pancreas, but the experience of a Cammidge is required to particularise the pancreatic disease.

In conclusion, I wish to thank Drs. Galley Blackley, Byres Moir, and Washington Epps, and Mr. Knox Shaw for their kindness in allowing me to use their clinical notes.

The paper was illustrated by the following microscopic specimens:—

- (1) Section of carcinoma of pancreas.
- (2) Section of secondary deposit in liver.
- (3) Section of hæmorrhagic pancreatitis.
- (4) Section of fat necrosis, showing fatty acid crystals.
- (5) Cammidge's pancreatic crystals from urine.
- (6) Crystals of gluco-sazone.
- (7) Crystals of lacto-sazone.

Dr. DYCE BROWN said members had been favoured with three interesting and valuable papers on an important subject, and he thanked the readers of them for the large amount of information to be derived from them. The treatment of diabetes by the old school was almost entirely diatetic. On the other hand, homœopaths could show great benefit from their method. The remedies which had been mentioned in the papers were those which he himself had found of most value; chiefly uranium nitricum in the third decimal, and afterwards in the second decimal, phosphoric acid and lycopodium. Arsenic was also valuable. Each case must be treated according to the indications for an individual remedy. One medicine which Dr. Blackley had not mentioned was of great service in certain cases, viz., hydrastis, *i.e.*, where the gastric functions were deranged, as shown by the coated tongue, loss of appetite, a bad taste in the mouth, and difficult stool. But the most interesting point about the disease in the matter of treatment was the diet. He (Dr. Dyce Brown) was utterly heterodox in regard to the adoption of a strict diabetic diet. He did not agree that that was the essential part of the treatment, or that it was of any real value in the *cure* of the disease. He looked upon the excretion of sugar in the urine as only a symptom of the disease, not as the disease itself, nor indeed as an essential part of it. The main question was, what caused the excretion of sugar? That question had not as yet been satisfactorily answered. Evidently there was some condition behind the mere symptom of sugar being excreted in large quantity. The system could not assimilate carbohydrates. What caused that lack of assimilation? This was a condition which had not been discovered. He thought it probable that some deep-seated nerve lesion was at the root of the trouble, but which had never been satisfactorily proved to exist. In practice the physician prohibited carbohydrates at one end by putting the patient upon a strict diet, the result was a diminished amount of sugar excreted. It was easy to prevent a flow at one end by cutting off the supply at the other, but were we nearer to the cure of the disease by doing that? He maintained that we were not, and his experience bore out that opinion. The result of a strict diet was that the patient became weak, lost flesh, went steadily downhill, abhorred his food, and became miserable, without advancing the cure in any way. Therefore for a number of years he had gone entirely on heterodox lines, not dieting the patient strictly at all, but letting him eat in the ordinary way, merely telling him to take as little

sugar as possible consistently with the necessity of using a certain amount for cooking purposes. His patients improved on such a plan of diet. At the same time the homœopathic medicine was given. Instead of going downhill in the matter of strength, patients improved, they enjoyed their food, slept better, and put on weight. In every way the general condition of the patient was improved under that treatment. Under the homœopathic *régime* there was diminution of sugar, or if not diminution there was no increase of that substance in the urine compared with its quantity when the patient was first seen. Since he began that method of treatment he had never seen cause to repent it. One patient who was under his care in the country wrote to say she was intending to come to London on the following Saturday, and that she was sure he would consider her greatly improved, as she felt so much better. During the first week or so she was weak and thin, and had been sleeping badly, and not relishing her food. But now the sugar had diminished in quantity, she was stronger-looking, and better in every way, as her friends remarked. She now slept well also, enjoyed her food, and was not troubled with constipation, whereas formerly she was constantly taking pills for the purpose of keeping her bowels regular. That change was wrought upon ordinary diet, without any restriction. So long as he found such a result in his cases of diabetes he intended to adhere to his present plan of treatment, looking upon the excretion of sugar as merely a symptom of the disease, and regarding the real disease as one which was to be combatted by internal remedies. He was not singular in these views in the homœopathic school, as he knew that several of his colleagues adopted the same plan. Among these he instanced Dr. Burwood, who was an excellent observer and a very careful practitioner, and whom he met some time ago in consultation over a case of diabetes. He had not known Dr. Burwood's views on the subject, but at the consultation he found they were the same as his own.

Dr. BYRES MOIR remarked that after hearing the first two papers he thought his mind was clear on the subject, and felt he had a good deal to say in connection with his experience in the treatment of the disease. But Dr. Watkin's paper intervened, and that brilliant contribution had had the effect of turning his thoughts in another direction. Dr. Watkin's paper certainly contained much food for thought and reflection. Still, he would mention his own experience in relation to diabetes and glyco-

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suria, not from book knowledge, but from practice. The first question was, were authors of papers and members of the Society not really speaking of two or more diseases? That was a most important matter, because in treatment all depended on the answer to that question. His experience was that two very different conditions were included under the head of diabetes, and that impression was very well supported by the cases which had been related that evening. True diabetes mellitus in children was quite distinct from the gouty glycosuria met with in adults. Yet there came a period in cases of gouty glycosuria when it was difficult to differentiate it from the other form; but in these cases there was not the same degree of polydipsia. One of his patients recently died who had been under observation fifteen years. The patient was a stout Jewess, weighing about 15 st., of a very neurotic family, and of a highly-strung and sensitive disposition. During some years prior to her coming under his notice sugar had been found in the urine at intervals, and a curious feature in some of those cases was that sugar was found in the urine one day, and yet on the next there might be no trace. But uric acid was present, and it was in big fleshy persons that one usually found this faulty metabolism. The question of diet, which Dr. Dyce Brown had touched upon, was very important. He (Dr. Byres Moir) was sure a strict diet was beneficial in those cases. He had one case a short time ago, which came to him wasted and losing flesh. He put her upon strict diet, and in six weeks she came back with no trace of sugar. He told her she was so much better that she could relax her diet, and she did so. She came back a month later, and he found sugar present again. He warned her to be careful about her food, but the relapse frightened her, and she kept to the diabetic diet. She again came to see him, looking ill. He found no sugar in her urine, the weakness having been entirely due to the strict diet. On putting her on to ordinary diet she had enjoyed good health for five or six years. He thought cases of this kind should be put upon phosphoric acid with strict diet, and when the sugar had been reduced, ordinary diet could be resumed. There was another question about diet which appealed to him. A patient whom he had watched for years had the same trouble, sugar in the urine one day, and acid on another. Last year this patient was in Greece, and for gouty symptoms a friend persuaded him to take a diet by which gout was treated in that country, namely, eating Turkish delight, and that only, except water and a cup of coffee. The patient said he had never

He never

felt so well in his life as when taking that, and when he returned he was better than he had been for years. Cabmen and other drivers in the streets preferred Turkish delight for keeping away the cold, and probably these men were suffering from gouty glycosuria. In the case of diabetes in children there was an entirely different condition. The first form he believed was due to faulty metabolism, but in the second form there was something wrong with the internal secretion—whether of the pancreas or of the thyroid he could not say—and the sugar was then derived from the proteids of the body. Dr. Bodman mentioned a rapidly fatal case in a boy. A short time ago a case came under his (Dr. Byres Moir's) notice, in a girl of 17 years of age. On Friday she was in the country, having been, apparently, in perfect health, and in the afternoon played hockey. On Saturday her mother, who was a nervous woman, noticed that the girl did not look well, and had a doctor to see her. She had white tongue and seemed heavy, and not her usual self. Sugar was found in the urine. As Dr. Moir had seen the girl previously, she was brought to him in London. He found her breath strong, that she was wasting rapidly, and was passing large quantities of water. He gave the worst prognosis he could, and said he would like Sir William Roberts, who had been recommended to the patient, to see her at once, as he did not think she would live long. The girl died on the Sunday. He agreed that in such a case as that a great deal of harm would be done by a strict diet, for by that means the chance of the patient getting better was taken away.

Dr. ROBERSON DAY confined his remarks to a few cases, each of which illustrated some particular feature of the disease. There was so much confusion of thought as to the real cause of the disease that it could be readily understood why some physicians obtained results very different from those of others. One often met with a case of physiological diabetes or physiological glycosuria, where considerable quantities of sugar were passed, and which might have been mistaken for genuine diabetes, although no attendant symptoms were evident. With regard to the disease in children, he could quote some figures from Holt's book, in which several authors were cited who had met with large numbers of cases. Pavy found that out of 1,360 cases only eight were under 10 years of age. Prout, out of 700 cases, had only one under 10 years. Myers gave 380 cases, only one of which was under 10. Not long ago a girl of 13 was brought to him severely ill with diabetes. She had been to Dr. Pavy previously.

The disease had come on insidiously during the last four months. The chief symptoms noticed were lack of energy and wasting. The local doctor, at the second interview, hearing that she was very thirsty, examined her urine, and found a large quantity of sugar. Dr. Pavy pronounced a very grave prognosis—only eighteen months to live, and the girl was brought to Dr. Day. The urine, on three separate analyses, gave 33, 37, and 39 grains of sugar. He prescribed phosphoric acid, but it was a rapidly progressive case. She improved after the phosphoric acid, but it was soon found impossible to keep her to a strict diet. She lived for four and a half years, and latterly used to eat almost anything, but always large quantities of meat. She finally died of coma, which came on very suddenly without any warning, and while her parents were away from home. The family history was instructive, phthisis was marked on the father's side, two of the patient's sisters having died of it; and a connection with phthisis was not infrequent. He had met cases of glycosuria associated with phthisis when he was at Brompton Hospital as house physician. Another case was that of a boy, aged 18, where the disease was traumatic in origin, the boy having hit his head against a chandelier. That gave great trouble at first, from severe pain in the head, and subsequently glycosuria developed, and in spite of treatment it ended fatally. The boy was previously healthy. Another case which came under his notice was one in which there was death from coma. Coma was the first indication of anything wrong. It was supposed at the time that the patient must have taken an overdose of laudanum, and not until sugar was discovered in the urine was the cause known. Another instance was that of a boy, aged 15, who acted as newspaper boy at a Smith's stall, where his appearance as a "living skeleton" attracted attention. He (Dr. Day) spoke to the boy on the station, and was told that he had diabetes and was under treatment at a hospital. Ultimately the boy disappeared; but he seemed to have mental energy so long as he had any strength left. The next case was that of a gentleman, aged 61, who had had diabetes for ten years. So long as he lived carefully he went on well. He came over to England without sufficient clothing, and on May 10 caught a severe chill; after that the disease came on with increased violence. The temperature sank, and that was a grave omen when associated with sugar. There were 19·3 grains per ounce of urine, the pulse rate was increased, the temperature continuing subnormal. He tried transfusion in that case, and he had the advantage of seeing Dr. Dyce Brown in consultation.



The diet was modified in accordance with the views of that gentleman, and phosphoric acid and belladonna were given chiefly. The patient rapidly became comatose.

Dr. BYRES MOIR remarked that the mother of the patient he had referred to weighed 24 st., and that an aunt had just died of diabetes. So the family history in that case was very strongly in favour of the occurrence of diabetes.

Dr. NEATBY expressed his warm thanks to the authors of the papers. Until he saw Dr. Blackley's synopsis he had never heard of "conjugal diabetes," but it brought to his mind cases of glycosuria in two elderly people whom he had had an opportunity of watching. Both were thin persons. The husband developed carbuncles on the nape, and shortly afterwards the wife developed boils about the vulva. The man lost all his sugar, and eventually died from an attack of bronchitis. The woman had persistent glycosuria and loss of flesh, developed vertigo, then mental delusions, and died from acute mania. Dr. Moir had gone to the root of the matter in regard to diet; there were different diseases giving much the same symptoms, and it was of no use to make fixed rules as to diet; in fact, the same patients might require different diet at various times. He had observed the truth of the advice he received from Dr. Sutton in his student days to be very chary about modifying the diet of elderly people. So he encouraged such patients to eat with reasonable freedom. But even this advice must not be slavishly followed. He remembered one case where it was prescribed, and after a time he noticed that the health had greatly deteriorated, and the patient became so weak that he could scarcely walk across the room. He then found that the sugar had increased from 50 to 1,400 grains a day. He was therefore put upon a very rigid diet, and very rapidly recovered his tone and voice. The patient was now over 80 years of age; he saw him occasionally, and he was quite well. While that patient was under observation, with thirst, a red, parched tongue, and polyuria to the extent of 100 ozs., he also suffered from an enlarged prostate, and, on theoretic grounds, he thought testicular extract might do good, but he had not heard of it having been used. He also gave adrenalin, because the frequent use of the catheter caused considerable bleeding. That combination brought about a remarkable improvement in the patient's condition. He also had had a case which bore upon Dr. Watkins' paper, and was ultimately supposed to be acute inflammation of the pancreas. He was called to see a patient of Dr. Croucher, of Eastbourne, for what appeared to be acute intestinal obstruc-

tion; there was a rapid pulse, great abdominal distension, and constant vomiting and cyanosis. The abdomen was opened, and the intestines carefully inspected, but no obstruction was found, though there was much thickening about the head of the pancreas. The patient died a short time afterwards, and the autopsy showed acute inflammation and much swelling of the pancreas.

Dr. STONHAM asked whether the acid in the blood was not in great measure due to the decomposition of the sugar, and whether that was not an argument in favour of strict diet. Where the blood was obviously saturated with acid, and there was danger of the onset of coma, surely the diet should be strictly limited, especially as to sugar. He would like to hear if any one present had had experience of nitrate of silver in diabetes; it had been recommended by different authorities in homœopathic literature. The pathogenesis of nitrate of silver showed a desire for sugar, and complaints were made worse by taking sugar. Another symptom was polyuria, but not, he believed, glycosuria.

Dr. MACNISH referred to a patient who had suffered from diabetes of a pronounced degree, and had a very large axillary abscess. She was comatose when he was called to see her, and, from the symptoms, he gave pyrogenum 30. She was now having *rhhus aromatica*. Though the sugar was still in excess, she was comparatively well.

Dr. BLACKLEY, in reply, said he had been somewhat surprised at Dr. Dyce Brown's sweeping condemnation of restricted diet for diabetics. He thought Dr. Dyce Brown must at times have had cases which had been on a restricted diet for a long time and done very well, but who, on some slight indulgence in sugar or other carbohydrate, had had a relapse and had manifested far more sugar in the urine than could be accounted for by the quantity of sugar ingested. It appeared as if the system were in a state of unstable equilibrium, so that very little indulgence was sufficient to upset it. He himself frequently had a feeling that, after all, it was not worth while strictly combating the disease, and that the patient might as well be allowed to enjoy life, or the little which remained to him; but those feelings could not be indulged in practice. He was also surprised to hear Dr. Moir say that the obese glycosuric was not usually a thirsty person. That, he thought, was precisely the type of person who was thirsty, and instanced the case of a man at present an inmate of Hahnemann Ward. He now weighed 18 st., but less than twelve months ago turned the scale at 20 st. He was passing from six to



nine pints of urine, containing a large proportion of glucose. The quantity of liquid ingested was never less than six pints, and, if allowed, the patient says he could drink twice the quantity. He agreed with the idea of there being at least two essentially different diseases. He had no experience of *argentum nitricum* for the disease.

Dr. BODMAN thanked those who had discussed his paper. One pint of saline solution was injected, but, as the patient was moribund and practically dying, no further quantity was used. The general opinion seemed to be that transfusion was but a temporary measure. Since Mr. Dudley Wright has shown that the effect of acids is to increase the alkalinity of the blood, while the latter is greatly lowered previous to and during the occurrence of diabetic coma, one would expect more result from the administration of phosphoric acid.

Dr. WATKINS, in reply, said that in a case which was under the care of Mr. Wilkinson, of Windsor, he made examinations of the urine for Mr. Wilkinson several times. The first time there was about 5 per cent. of sugar in it. The following week it only just gave a reaction to Fehling's solution. Other samples since received were free of sugar. Two drops of adrenalin solution were given three times a day. He thought one other organ was sometimes at fault in the disease under consideration, besides those mentioned by Dr. Moir, namely, the kidney. The phloridzine glycosuria differed from all other kinds in two respects: the blood contained less glycogen and glucose than normal, and also gave no reaction with Williamson's and Bremer's tests. These tests are constant in all other kinds of glycosuria. The conclusion was that the kidneys had lost their power of damming back the sugar in the blood. Clay, Paget and Co. were making a milk which contained no lactose, and he had two breads highly recommended to him because of their palatability, which contained no starch. They were called protein and casoid. He thanked the members for the way they had listened to and discussed the subject.

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## HAHNEMANN TER-JUBILEE FESTIVAL.

THE year 1905 is the 150th anniversary of the birth of the founder of the homœopathic system of medical practice. Samuel Hahnemann was born on April 10, 1755, and his birthday this year has been celebrated with becoming honour by homœopathic institutions throughout the world. Not the least conspicuous of these celebrations was the Festival Dinner and Oratorical Commemoration of the event by the British Homœopathic Society, which took place at the Hotel Cecil, in London, on the evening of the Hahnemann birthday.

The President for the year, Dr. James Johnstone, B.A., F.R.C.S.Eng., took the chair at 7.30 p.m.

Dr. Cartier, of Paris, as representing the Homœopathic Society of France, sat on the right of the President. He had come over to England specially to unite with the British Homœopathic Society in celebration of the event.

The following Fellows and Members of the Society were present, namely, Dr. James T. Ashton, Dr. Arthur A. Beale, Dr. J. Galley Blackley, Dr. D. Dyce Brown, Dr. George Burford, Dr. Herbert E. Deane, Dr. Washington Epps, Dr. Sydney Gilbert, Dr. Giles F. Goldsbrough, Dr. Victor A. Jagielski, Dr. John McLachlan, Dr. David MacNish, Dr. Edward M. Madden, Dr. Byres Moir, Dr. John Murray, Dr. Herbert Nankivell, Dr. Edwin A. Neatby, Dr. Charles Renner, Dr. James Searson, Mr. C. T. Knox Shaw, Dr. Thomas G. Stonham, Dr. H. Wynne Thomas, Mr. Dudley D'A. Wright. The Society was honoured by the attendance of the following gentlemen as guests: E. A. Attwood, Esq.; F. Bert, Esq.; Nicol Brown, Esq.; Harold Burford, Esq.; Professor D. S. Capper; J. Howard Carter Esq.; F. W. Cheetham, Esq.; J. Churchill, Esq.; Colonel F. B. Deane, Colonel G. W. Deane, Captain F. Gunter, R.A.M.C.; B. Gott, Esq.; Rev. Dr. Hanson; Dr. Hayes; Percy Hull, Esq.; S. H. Kluht, Esq.; Lyon Mackenzie, Esq.; John Jones, Esq.; F. J. Rees, Esq.; H. Schmalz, Esq.; T. A.

Meissen in 1780.

Meissen in 1905





Spalding, Esq.; Thomas W. Stephens, Esq.; C. Stewart, Esq.; Mazzini Stuart, Esq.; H. Thomson, Esq.; H. Whitehorn, Esq.

After dinner the toast of "The King" was given.

A letter of apology for absence was read from Dr. Suss-Hahnemann, grandson of Samuel Hahnemann. He greatly regretted his inability to be personally present to do honour to his illustrious grandfather.

The President then rose and said:—

"After the toast which we have just honoured, our first word this evening will be one of welcome, on behalf of the British Homœopathic Society, to our guests both lay and professional. This is pre-eminently an occasion in which our patients as well as ourselves are interested. We are mutually dependent on each other, but both are primarily dependent, the one for livelihood, the other for care of life and health, on the benefits conferred by him whose memory we are this evening assembled to honour.

"We are not here to mourn the loss of a colleague and benefactor, for he has long since been called to his rest, after an unusually extended life of busy work and usefulness; but the keynote of this assembly should be one of joy and gratitude; joy at the birth 150 years ago to-night of our master, Samuel Hahnemann, a brilliant scholar, an advanced medical reformer, an eminent scientist and a most successful physician; gratitude for the untold and increasing influence brought by him for the good and well-being of thousands of suffering humanity. 'We come not to bury Cæsar, but to praise him,' if I may be permitted to rearrange the words of our immortal playwright. 'The good men do, lives after them—the rest is buried with their bones.' Of few men can this be said more truly than of Hahnemann.

"How marvellous and far-reaching has been the effect of Hahnemann's spirit and teaching on that particular cult of medical practice with which we are more particularly associated, and how much for the last one hundred years has that influence been felt on the more general practice of medicine, particularly in the abandonment of blood-letting, the use of the single remedy, the purification of the *materia medica*, and the lessening of the dose! His principles have been adopted by thousands of disciples in many lands. These disciples will ever have a special bond of kinship between them, a kinship of loyal allegiance to a common Master. That such an international bond is no mere fancy of a

dreamer, the fraternal relations with colleagues in other countries constitute indisputable evidence. What else but such a spirit has prompted a distinguished colleague from the fair capital of France (and some would say of Europe) to come and join in this, our evening of commemoration! Not only are we eager to extend to him a hearty welcome for his own personal worth and high standing as a physician, but also for his being the bearer of friendly greetings from our colleagues across the Channel. May this Hahnemannic link in the rapidly strengthening chain of the *entente cordiale* be hall-marked as sterling gold by the impressions of fraternal feeling and good-fellowship which we must see that he carries back to those whom he represents.

“Our honoured colleague and guest, Dr. Cartier: on behalf of the British Homœopathic Society and its friends here assembled, I offer you a most hearty welcome. It gives us untold pleasure to have your presence and message on this occasion, and we beg of you, when you return to your fair city, to convey our warmest greetings to our brethren in France, to assure them of our sincere and hearty good wishes, and of our most loyal support in the common cause of homœopathic principle and practice, and, as a token of this our regard, I extend you the right hand of fellowship.

“To our other visitors this evening we also extend a hearty welcome. We are cheered by your presence and support, and trust that you in turn have satisfaction in the physiological and intellectual fare that we have to offer you. A word of apology may here be uttered to the ladies, who, I am given to understand, are much aggrieved at not being summoned to our gathering. We humbly confess our shortcomings and hope to make amends in some slight measure by asking them to grace us with their company at the London Homœopathic Hospital to-morrow afternoon, when the collection of Hahnemann relics will be on view.

“In the years that are past a Hahnemann dinner has been a frequent festival. We remember on these occasions hearing and seeing the true and trusty members of the ‘old guard’ in British homœopathy. Alas, how few of them now remain! For this year the Council felt we could not do better than revive this function, which has fallen into abeyance for some years. Hence your summons here this evening. But we have for various reasons departed from the time-honoured plan of an extended toast list. So long a time has elapsed since the death of the founder of homœopathy, that we are inclined to forget or

cease to enquire into the life and character of one who in the domain of medicine was such a power in the land in the early part of last century. To counteract this lapse into forgetfulness, and to refresh our memories of the man, his versatile abilities and general life-work, the programme before you has been framed. To me, a most unworthy but willing exponent, has been entrusted to give you

“ ‘A BIOGRAPHICAL SKETCH OF HAHNEMANN.’ ”

“ For one of the younger generation, without personal acquaintance or traditional information regarding our master, this is, I feel, a somewhat bold undertaking ; but it has been rendered light by being able to refer to standard works on Hahnemann, namely, ‘ Dudgeon’s Lectures on Homœopathy,’ and Bradford’s ‘ Life and Letters of Hahnemann.’ Of these I have made considerable use and would like to acknowledge my indebtedness. The most recent contribution to the literature of this subject is from the pen of Dr. Richard Haehl, Secretary of the Homœopathic Society at Stuttgart, named the *Hahnemannia*. This excellent sketch of Hahnemann’s life, containing many new points of interest collected on the spot, is the commemorative *Zeitschrift* of that Society—which did honour to the ‘ Meister ’ on April 2, some days in advance of the actual anniversary date. My best thanks are due to Dr. Haehl for forwarding me a copy of his work, of which I have made use by reproducing some of his new and interesting illustrations. To add to the interest of this ‘ Biographical Sketch ’ I have ventured to give lantern illustrations, in the hope that they will be acceptable. These have been copied from various sources, and for providing me with material, I am particularly indebted to Dr. Suss-Hahnemann of Ventnor, Dr. Paul Lutze of Cöthen in Anhalt (successor there to Samuel Hahnemann), Dr. Willmar Schwabe of Leipzig, editor of *Popular Zeitschrift für Homœopathie*, Dr. Cartier of Paris, Dr. Peter Stuart of Liverpool, and his sister, Mrs. Stephens of Richmond. These friends of our cause have my best thanks for their willing response to my requests.

“ The story of Hahnemann’s life takes us in place to the centre of Germany, and in time to the middle of the eighteenth century, when, on April 10, 1755, he first saw the light. His father, Christian Gottfried Hahnemann, son of a painter, Christoph Hahnemann, in Lauchstadt, near Leipzig, had gone to Meissen to carry on his profession of a painter on porcelain in the Royal Factory there. Meissen is a picturesque little town

on the Elbe, a few miles north of Dresden. Its principal feature is the Albrechtsburg, an ancient and picturesque ducal castle on a hill, in which the first porcelain factory found its origin. Later, the Royal Factory has been located on the outskirts of Meissen in the Triebisch valley. Hahnemann's mother, Johanne Christian Speiss, the daughter of a captain in the Weimar-Eisenach army, gave birth to her eldest son, Samuel, in a house standing but a few months ago at the corner of the Streets Neumarkt and Fleishsteg, and popularly known as the 'Corner House.' Of recent years it has been occupied by a restaurant,

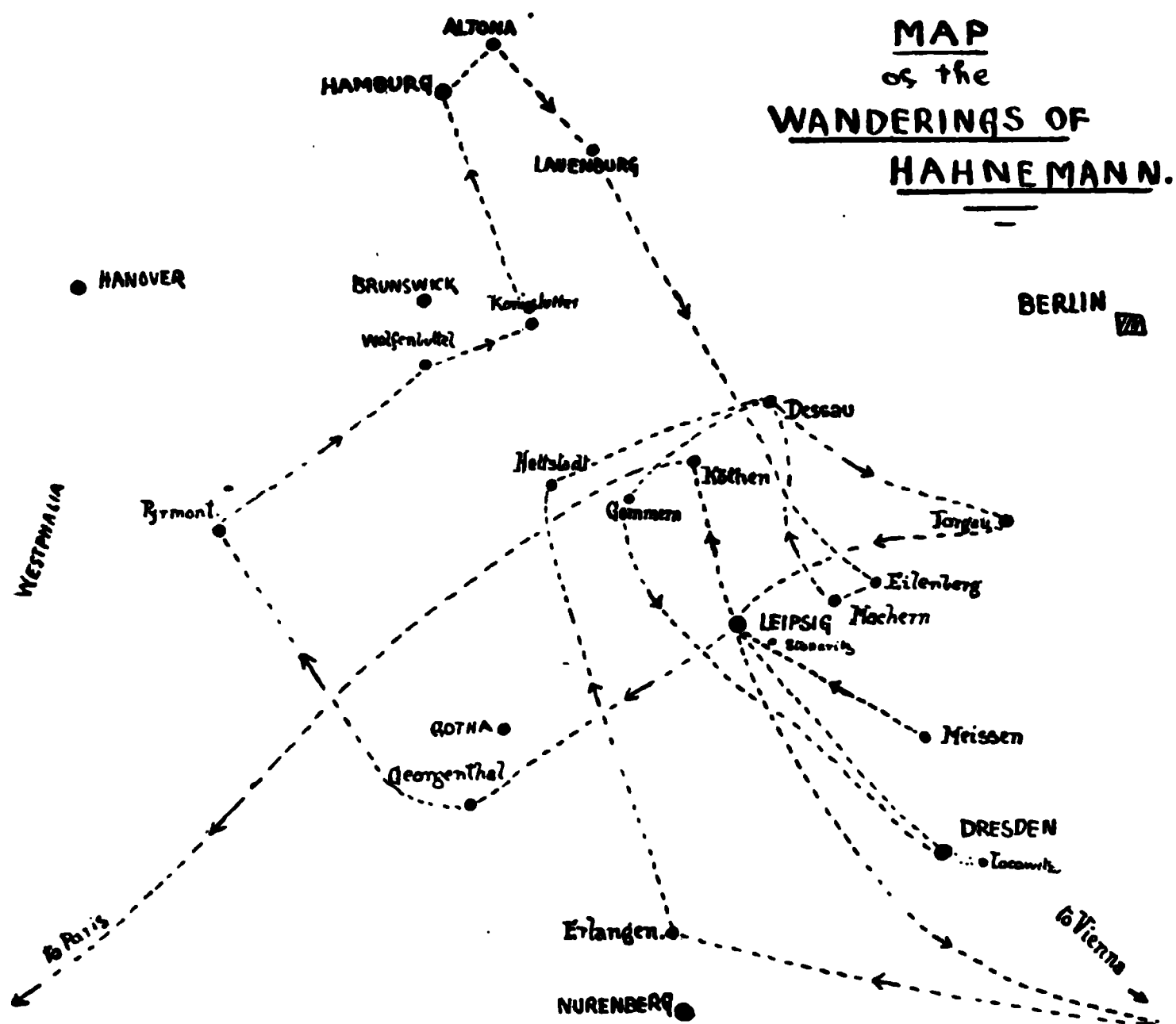
Hahnemann's birthplace as a restaurant.

Present building on site of Hahnemann  
restaurant.

rejoicing in the name of 'Hahnemann Restaurant,' till replaced recently by a more pretentious building. In this beautiful Saxon town, surrounded by hills on one side and the majestic Elbe on the other, Hahnemann spent his boyhood days. For his Fatherland, Saxony, he had the greatest love, and frequently returned to it during his many and varied wanderings. As a boy he was a diligent student, much against his father's wish, and often sat late into the night studying surreptitiously by the aid of a clay lamp which he made and concealed for the purpose. These student habits, early acquired, never left him, and the wonder



is that his sedentary habits seemed to detract in no way from a long and healthy life. At the age of twenty, on his own entreaty, his father gave him his portion of 20 thaler (about £3), and sent him to the University of Leipzig to study medicine, where, in addition to attending classes, he supported himself by teaching English and German and translating English books. He next journeyed to Vienna, where he found a worthy Dr. Von Quarin, who assisted his studies. But funds being wanting, he undertook the post of librarian and physician to the Governor of Transylvania, in the town of Hermanstadt, necessitating a



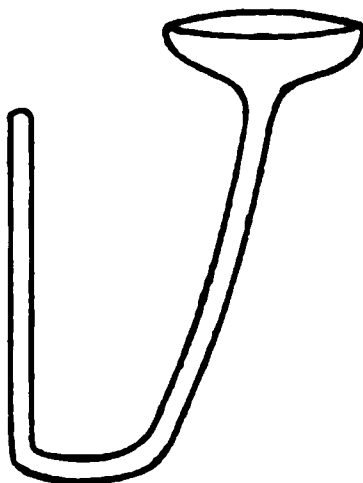
journey into the south-east of Austria-Hungary, a journey of some magnitude in those days without railways. Thence we find him proceeding to Erlangen to complete his studies and take his diploma in medicine. To his Fatherland was the next move in 1779, and he practised at Neustadt, Dessau, and Gommern successively. It was at Dessau that he met and married his first wife, Johanna Küchler, daughter of an apothecary. Dresden was the next halt in his itinerary, where he almost entirely relinquished the practice of medicine and devoted himself to

chemistry. As a result we have from his pen a treatise on 'Arsenic and Arsenical Poisoning,' which at once took its place as a standard work on the subject, and is one of the first evidences of the author devoting attention to the study of pharmacology, on which the basis of his great life-work was laid.

"In 1789 we find him at Leipzig, writing on syphilis and announcing the discovery of his method of preparing *soluble mercury*. Next year, 1790, will ever be memorable to us as homœopaths, for in it the earliest glimmering ideas of the guiding principle he afterwards inculcated, "*Similia similibus curantur*,"

U n t e r r i c h t  
f ü r  
**W u n d ä r z t e**  
über die  
venerischen Krankheiten,  
nebst einem neuen Quecksilberpräparate.

v o n  
**Samuel Hahnemann,**  
der Arzneik. Doct.



Leipzig, 1789.  
bey Giesfried Seubach & Crusius.

Title page of Hahnemann's Work on Venereal Diseases, shewing his apparatus for urethral irrigation.

first dawned on him. While translating Cullen's 'Materia Medica' he was struck by the reputed fever-producing property of cinchona bark. At first he considered this preposterous, and then, in the words of Dr. Lippe, quoted by our revered departed Richard Hughes, 'this good and benevolent man had an "in-

spiration." He concluded to take the drug himself, and see whether light could not be brought into the prevailing darkness. Bright and early in the morning Hahnemann went to the 'Apotheke zum Goldenen Loewen' in the market-place of Leipzig, and there and then selected some fresh cinchona bark and obtained some vials and alcohol. He prepared a tincture, took it, and behold the symptoms he observed in himself showed a marked similarity to cases of ague cured by him by the same drug. And it was then a new light dawned upon him; that light was this: 'A drug will cure such ailment as its sick-making

*Meinen Leberingenossen Herrn Dr. J. H. Wolff.*

*Lieber Freund!*

*Ich bevollmächtige Dir hiermit, in meinem Namen vom Herrn Briefträger Arnold in Vordruck mein Manuscript vom neuen Efficil der chronischen Krankheit abzuverlangen, wenn er Ihnen nicht durch früherer den gedruckten Probenbogen das Gefühl, daß dieser neue Efficil schon oder fast bereits schon abgemittelt ist.*

*Cöthen,*

*4. Hr. Johann Valer*

*Samuel Hahnemann*

Letter of Hahnemann to his publisher, referring to MSS. of "Chronic Diseases," with Seal.

power will produce a similarity to' (*British Journal of Homœopathy*, vol. xlii, p. 8). This first proving by Hahnemann on himself was the precursor of a vast array by himself and his disciples, and it is on this firm basis that the superstructure of homœopathy so firmly stands.

"About this time an increasing family, slight success in practice, and inadequate remuneration for his literary work, brought him into the very depths of poverty, so low that he and his family had to share one room, and had often to do without

the bare necessities of life. Yet Hahnemann's elastic and buoyant spirit rose triumphant midst the depression and gloom of such surroundings. A way out was provided when he took charge of an insane asylum at Georgenthal in the Thuringian Forest, offered him by the Duke of Saxe-Gotha, where he made a famous cure of a court minister by adopting, for the first time in Germany, that humane treatment of the insane now so successful in modern times. In this, as in other departments of science and medicine, Hahnemann always illumined the darkness and ignorance of prevailing ideas by some fresh inspiration, foreshadowing and forestalling the advanced practice of a century later. Also about this time he advocated the use of belladonna in scarlet fever. This, and his successful treatment on new lines of the insane minister Klockenbring, brought him into violent collision with his medical colleagues, and from that time on he suffered the most persistent and ill-natured persecution. Thus began his 'years of wandering' from place from place; no sooner had he settled down than the agents of the Apothecaries' Society hounded him out, for by law only chemists could compound medicines, and Hahnemann by preparing and giving his own single medicines infringed their rights. Imbued by the same motives as the silversmiths of Diana, who by the teaching of St. Paul found their trade in danger, they gave him no peace, and so we find him within the space of a few years at places so widely apart as Walschleben, Pyrmont, Wolfenbüttel, Königsutter, Hamburg, Altona, Möllen, Eilenberg, Mächern, Dessau, and Torgau. The hostility to him was such that he had to give up writing in medical journals and translating scientific works. Henceforth he was compelled to publish his work himself, or in *Hufeland's Journal*, a popular paper. In this latter appeared his exposition of the homœopathic principle in an article entitled, 'The Medicine of Experience,' which brought him added calumny and persecution. Next appeared, in 1810, the first edition of his immortal 'Organon,' which was an elaboration and exposition of his matured ideas. By this time practice and fame increased, *pari passu*, and he returned to Leipzig 'on the flood-tide of fortune' (Dudgeon's 'Lectures on Homœopathy,' p. 31).

"Quoting Bradford, 'What a marvellous variety of changes had compassed the life of this man since the time when he departed from the great city, a boy of twenty-two, with the future all before him! Vienna, Hermanstadt, Erlangen, Dessau, Gommern, Dresden, the momentous discovery at Leipzig, Georgenthal, the 'wander' years afterwards, and Torgau with its literary

The house in which Hahnemann was born, Meissen,  
April 10, 1755.

House in Cöthen where Hahnemann lived and practised,  
1821-1835.

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results, until now, with a name well known in all Germany, with a new and superior system of medicine to his credit, he, a man of fifty-six years, and, as he called himself, cosmopolite, once more turns towards the scene of his earlier student life. Trial, sorrow, privation, malevolence, falsehood, all had followed him like shadows, yet had he gone patiently and manfully on in the path he had determined to follow. Now he returned to Leipzig to teach to others the truths that God had permitted him to discover; to disseminate a certain law of healing for the good of his fellow-men.'

"To qualify himself for the privilege of giving lectures to his pupils at the University of Leipzig, he had to pay a sum of money and defend a thesis. This produced his famous essay, *De Helleborismo veterum*, 'The Hellebore of the Ancients,' a work showing such minute research, classical scholarship, intimate knowledge of languages and of science, that he astounded the faculty, and his adversaries in particular. To compile this work he must have read carefully in the original Greek, Latin, and Arabic, the works of fifty physicians from Hippocrates down to his own day. To quote 'Dudgeon's Lectures' (p. 32): 'This trial, which his enemies had vainly hoped would end in an exposure of the ignorance of the shallow charlatan (as they called him), triumphantly proved the superiority of Hahnemann over his opponents even on their own territory, and was a brilliant inauguration of his lectures,' which became famous and thronged. But here I fear to tread further, as I may find myself stealing the thunder from the oration on 'Hahnemann as a Man of Letters,' in which this aspect of Hahnemann's attainments will no doubt be amply and brilliantly dealt with.

"Time does not permit me to allude to the controversies Hahnemann was embroiled in with his opponents, or of his continued difficulties with the apothecaries, who still were like sleuth-hounds on his track. They made it almost impossible for Hahnemann to earn a livelihood by practice, without his having to modify his methods of dispensing. At this moment of discouragement and despondency, when the future was dark and obscure, a light appeared to chase away the clouds of despair.

"The Prince of Anhalt-Cöthen, who ardently adopted Hahnemann's teachings, offered him absolute freedom to practise in the town of Cöthen, the capital of the State. Hither he repaired in 1821, evading thereby the restrictions and persecutions of his enemies the physicians and chemists, to find himself armed with princely authority to do what he liked. No doubt it was with

reluctance that he said good-bye to Leipzig, the city of learning and art, of busy life and pleasing surroundings, to immure himself in a little country town, a veritable sleepy hollow. As Court Physician he enjoyed many privileges and honours, but he missed his disciples and his provers. However, he found abundance of employment in practice and literary labour, publishing successive editions of his 'Organon' and 'Materia Medica.' New work also engaged him in the writing and publication of his famous 'Chronic Diseases.' His followers in Leipzig and throughout the country remained faithful to him and grew in numbers daily, to such an extent that he was able to found in 1829 the first homœopathic society—'Central Society of German Homœopathists.' This was on the festival occasion of the fiftieth anniversary of obtaining his doctor's degree. He was fêted and lionised by an admiring assembly of his followers, drawn from all over the country to do honour to their master. His portrait in oils was presented to him, and by the kindness of Dr. Suss-Hahnemann, of Ventnor, I am able to show you a reproduction of it.

"In the following year Hahnemann lost his wife, the sympathetic sharer of his joys and sorrows (and the latter were many) for fifty years. Much has been written as to the personality of the lady, but I am inclined to take Dudgeon's view when he writes: 'It has been stated that this good lady had not the sweetest of tempers, and that she was somewhat of a Xantippe to our Socrates; but, as far as I can learn, there is no ground for this accusation. There is no doubt that she was a most affectionate wife and mother, but at the same time a strict disciplinarian who asserted her supremacy over the domestic affairs and over her husband, in as far as he was part and parcel of the household. That Hahnemann loved and highly esteemed her, we have ample evidence from many passages in his letters and from the testimony of his friends.'

"While at Cöthen, there occurred a brilliant example of Hahnemann's application of his guiding principle. The cholera was invading Europe by way of the East. Hahnemann heard of its coming, and, acquainting himself with its characteristics, sought out the remedies suitable to combat it, printed directions accordingly, and distributed these widely. By this means the prophylaxis and treatment were so successful when in time the dread disease duly invaded his neighbourhood, that there was established a convincing proof of his method which gained for him and his system much sympathy and support.

"Not only in Germany, but in foreign countries even as far as



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**Hahnemann's First Wife (*née* Küchler).**

**Portraits of Hahnemann and his First Wife about 1829.**



**Prince Ferdinand of Anhalt Cöethen,  
Hahnemann's benefactor.**

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America, his views and practice were advancing, and exciting the hostility of the old school. Hahnemann was at last beginning to find his labours bearing world-wide fruit.

“What a solace the life at Cöthen must have been to Hahnemann, with peace, prosperity, liberty, opportunity to write, and the success of his system; all must have tended to make life during these fourteen years at Cöthen really happy and ideal for the scholastic tastes of Hahnemann, now in his eighth decade of life.

“But a wonderful change was in store for him. Suddenly, from the gay city of Europe, a talented and gifted young lady of noble birth appeared in search of advice from the renowned and aged physician. Doctor and patient became mutually interested, and the attachment culminated in marriage and departure for Paris. Naturally this romantic episode created quite a stir in his own family, in the town of Cöthen, and in fact all over Germany. Much has been written for and against the character and history of Mélanie d'Hervilly Gohier, who at thirty-five married an aged man of eighty. Still more surprising was the complete change in Hahnemann's life in Paris. At Cöthen, he was anything but sociable, hardly stirred beyond his own house and garden, received all his patients in his own room, and generally lived the life of a recluse. In Paris all this was changed. He visited patients at their own homes, attended the salons, theatres, and places of amusement, and entered with alacrity into the gay life of a gay circle in a gay city. Though he parted with the best of his fortune made at Cöthen to his family before leaving, in the following eight years he amassed another in Paris. But the endurance of the human frame has its limits, and Hahnemann survived his migration to Paris but eight years, and died full of years and honours at the age of eighty-nine on July 2, 1843.

“Such is a brief sketch of the life of this great man, eminent as a scholar, a scientist, and a physician, whose indomitable perseverance and brilliant gifts enabled him to educate himself, endure poverty and distress, wander over the face of the country with an increasing family, be hunted by his enemies, defeat them ultimately with their own weapons, found a school of thought and practice in medicine, write a legion of books, pamphlets, translations, &c., and yet make two fortunes in the practice of his profession.

“To my colleagues who follow me I must leave the congenial task of laying before you some of the many-sided aspects of this great man, who by Jean Paul Richter was called, ‘This double-headed prodigy of philosophy and erudition.’

"In conclusion, let me add a few words about the various monuments to his memory, and the estimate of his worth and work at the present day.

"Hahnemann was interred by his widow Mélanie in the Montmartre Cemetery in Paris, in a grave adjoining her family vault, without pomp or ceremony, with no monument to mark the spot.

#### Hahnemann's Grave in Montmartre, Paris.

"Some six years ago when in Paris I made a pilgrimage to the grave, and had considerable difficulty in finding it, as there was nothing to distinguish it in any way. By the efforts of an international committee funds were raised, and by the good offices of our colleagues in Paris a suitable last resting-place was found for Hahnemann's body in the Cemetery of Pere Lachaise, whither it was transferred from Montmartre. At this disinterment in 1900, two persons were present who were at the first funeral, namely, Dr. Suss Hahnemann, of Ventnor, the grandson, and Mons. Ganai, whose father had charge of the embalming of Hahnemann's body. Their testimony and the finding of various articles deposited with the body were sufficient to establish its identity.

"In July, 1900, during the sitting of the International Homœopathic Congress, a handsome monument of Scotch granite was unveiled in the presence of a large number of physicians and admirers from all over the world.

Portrait about 1829.  
(Original in possession of Dr. Suss  
Hahnemann.)

Portrait by Hathaway, Paris, 1855.  
(Now in Philadelphia.)

Madame Melanie Hahnemann  
(Second Wife).

Portrait by Second Wife about 1842.

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“There in the Pere Lachaise Cemetery the remains of Hahnemann lie, as befitting his genius and fame, surrounded by others ‘who have left their footprints on the sands of time,’ amongst whom are Rossini, Auber, Donizetti, Racine, Molière, Gay-Lussac, Marshals Ney and Davoust, Gall, the founder of phrenology, and many others; names representative of the best in France in music, art, literature, and war.

“In America, where homœopathy has shown its most vigorous growth, a splendid monument has been erected at Washington. This was unveiled by President McKinley, and accepted by him as a National Monument at the hands of the disciples of Hahnemann in that great country.”

At the conclusion of his address the President proposed the toast of “The Immortal Memory of Hahnemann,” which was drunk in silence by all, standing.

The following oration was then delivered by Dr. McLachlan, of Oxford, on:—

#### HAHNEMANN AS A SCIENTIST.

“The atrocities committed in the name of *Science* have been, and still continue to be, very great. The needy charlatan, the race of ‘quacks,’ legalised and otherwise, past or present, glibly talk about the discoveries of science, and tacitly imply, or at any rate wish their dupes to believe, that their methods are founded on these discoveries and are therefore strictly scientific. ‘Science’ thus used, however, is more or less a modern adaptation of the word. Before the day of science, ‘tradition,’ a word of most ancient and hoary antiquity, held the field. Indeed, even now we sometimes speak of ‘traditional medicine.’ Now one can have nothing to say against tradition as such; but when it attempts to mould the present generation, just because it is tradition, *i.e.*, apart altogether from truth or falsity, we refuse to submit to be governed by this ‘dead hand,’ and claim the right to think for ourselves. In a book called *Job* we read that ‘Great men are not always wise’; and I would add, neither are majorities always right, nor are old sayings always true. Indeed, in many cases, if not in most, the traditions of the past have been the direct anti-theses of truth. Foulest blasphemies, justified by tradition, have over and over again masqueraded in the garments of truth, and claimed that allegiance which is due to the truth alone.

“How, then, are we to define ‘Science’? It is rationalised knowledge of observed facts, concerned mainly with the laws

regulating occurrences. In its widest application it is the bringing of the manifold phenomena of Nature to order and system, by discovery of the hidden conditions of existence—its one and only interest, to find out the ‘what’ and the ‘how’ of things. We distinguish ‘observational sciences’ from ‘exact science,’ such as mathematics, as all departments of the former depend for a beginning on a large accumulation of facts from which induction proceeds, whereas exact science depends on axiomatic truth.

“The distinguishing characteristic of science from our point of view is its *method of graduated verification*, not the employment of induction in lieu of deduction. ‘The true antithesis is not between induction and deduction, but between *verified* and *un-verified* cases of induction and deduction’ (G. H. Lewes). The truly scientific man verifies each stage of the process, guarantees each separate point, and proceeds to the unknown solely through the avenues of the known. We find all these points illustrated in a remarkable way in the labours of Hahnemann, whose scientific instincts and attainments were centuries in advance of his time.

“How, then, are we to account for this remarkable man, with his extraordinary mental endowments? Largely, I believe, to the ‘thinking lessons’ he had in childhood. When he was five years of age his father had a habit of giving his son Samuel what he called ‘thinking lessons.’ Did he then foresee that son’s future greatness? He used to say, ‘If that boy is permitted to grow up I will give him lessons in thinking: that boy must learn to think.’

“It is maintained by some ‘that an infant of genius is quite the same as any other infant, only that certain surprisingly favourable influences accompany him through life, especially through childhood, and expand him, while others lie close-folded and continue dunces.’ Herein, say they, consists the whole difference between an inspired prophet and a double-barrelled game-preserved: the inner man of the one has been fostered into generous development: that of the other crushed down, perhaps by vigour of animal digestion and the like, has exuded and evaporated, or at best sleeps now irresuscitably stagnant at the bottom of his stomach. ‘With which opinion,’ cries the Professor in ‘Sartor Resartus,’ ‘I should as soon agree as with this other, that an acorn might, by favourable or unfavourable influences of soil and climate, be nursed into a cabbage, or the cabbage seed into an oak. Nevertheless,’ continues he, ‘I, too, acknowledge the all but omnipotence of early culture and nurture: hereby we





Portrait by Schoppe, 1831.

Marble bust in Hôpital St. Jacques, Paris.

Statue at Leipzig.

Statue at Washington.



have either a doddered dwarf bush, or a high-towering, wide-shadowing tree; either a sick yellow cabbage, or an edible luxuriant green one.' That Hahnemann developed into 'a high-towering, wide-shadowing tree' was admitted alike by friend and foe. Under that shadow we are met to-night. Now, the *power of comparison* is the distinctive characteristic of 'thinking.' In this we see how, all unconsciously, the boy was father to the man, the man who, in due time, undertook the Herculean task of making a *Materia Medica*, where his powers of comparison shine out with unrivalled splendour, and of creating a new science—the Science of Therapeutics.

"In medicine all the errors which have gained acceptance in the past or present, have done so because the important principle of 'verification' has been neglected. The mind of man persistently leaps forward to 'anticipate' Nature, and is satisfied with such 'anticipations' if they have merely a *logical* consistence, *i.e.*, that they look all right in print. This anticipating of Nature, instead of questioning, watching, and following her, has been the curse of 'traditional medicine' ever since the time (and perhaps before) when Galen and Aristotle held that air circulated in the arteries, causing the pulse to beat and cooling the temperature of the blood, and were quite content with this plausible anticipation. But they forgot to verify the facts of the air's presence, and its cooling effect, and contented themselves with those unverified assumptions—assumptions that dominated the medical profession for something like 1,500 years. We do not blame Galen for guessing, but we do blame him for leaving his guesses *unverified*. The man of science of to-day guesses as freely as the ancients; but he knows he is guessing, and should he chance to forget it his rivals will quickly remind him that his guess is not evidence. Science, indeed, would be impossible without guessing; Hahnemann himself guessed the law of cure after his epoch-making experiment with cinchona bark; but every guess, every assumption he made, he treated as merely provisional and hypothetical until it had been verified. Therein, indeed, he showed the true scientific instinct, and earned the right to be placed for all time in the front rank of men of science.

"One sometimes speculates about the possible fate of scientific medicine (*i.e.*, homœopathy) had Galen never been born. Hippocrates (460 B.C.), I believe, had a distinct leaning towards homœopathy; but Galen came, some 600 years after, Hippocrates (130 A.D.), and diverted the principles and practice of medicine into another channel. Some 1,600 years after Galen,

Hahnemann, the 'Messiah of Medicine,' was born. Something similar happened in the history of astronomy. Pythagoras (570 B.C.) had taught men to regard the sun as the centre of our system. That truth held sway for some 600 years, when Ptolemy (1 A.D.) persuaded his contemporaries to abandon it, and for 1,500 years all the wisdom of the wise was on the side of error. In 1543 the great work of Copernicus was published, which gave the death-blow to the 'Ptolemaic System' and reinstated the Pythagorean hypothesis on a secure scientific basis.

"In Hahnemann's time medicine was quack-ridden—accredited and legalised quackery it is true—and all the wisdom of the learned men of the time, and of science falsely so-called, was on the side of quackery. Speciosity usurped the place of reality, appearance of performance the place of performance. The sick, dumb, inarticulate were pleading to be healed, mutely asking the medical hierarchy of the day, 'What can you *do* for us? Can you not heal us?' The reply was the answer of the priesthood of all ages: 'Are we not of God, and by Him invested with all power and authority? Have we not Galen to our father, though Hippocrates acknowledges us not? All the experience and knowledge of the ages is ours. What more can any reasonable man want? To die under such auspices is indeed glorious.

" 'Let sink the beggar if he will not swim,  
Upon the plank that *we* throw out to him!'

"From the very beginning of his career Hahnemann felt dissatisfied with medicine as practised in his day. As far as possible he cast from him the prejudices, dogmas, and false assumptions of the schools, and tried in various ways to mend and improve the methods of treating disease. He abandoned vain, empty speculation, and began to interrogate Nature herself, with the result that to-day we are in possession of a science of therapeutics.

"From this we also learn the false and erroneous nature of a doctrine very much in vogue at the present day, viz., that a man is just what heredity and environment make him—a sort of *additive* reaction, no more and no less. Now we do not deny the immense and far-reaching influence of both heredity and environment, but those who maintain the doctrine forget that man is a self-conscious being, and can make his own environment if he so wills it. Hahnemann, dissatisfied with his old environment, breaks through it and forms an entirely new one for himself.

"When Hahnemann became convinced of the inutility and mischievousness of current medical methods, he did not continue

a routine practice for the sake of 'making a living.' A noble and honest man, he refused to make a pretence of curing where he *believed* he did *not* cure. He therefore gave up the practice of medicine and devoted himself to the collateral science of chemistry and to literary labours. An honest man is the noblest work of God! He was also a reverent man, for he was 'sure that the Creator had not left His creatures without a means of succour from the pangs and ravages of disease.' He was no Deist: he did not believe in a Creator Who, having once set the world agoing, withdrew Himself from all connection with it—becoming an absentee Creator, looking on from a distance and watching the 'wheels go round.'

"Nevertheless, at this crisis of his life a horror of great darkness enveloped him, but still his mind was ever at work on the great question of the improvement of the practice of medicine. Doubt can only be removed by action. In this period of darkness and chaos he heard the 'inner voice' saying, Be true to thyself: do the duty that lies nearest thee—that comes next; to the honest and *straight* in heart light shall arise! Then there came a moment, a Divine moment, when over the tempest-tossed soul of Hahnemann, as over the wild, weltering chaos of old, came the word, 'Let there be light!' Discord is hushed and the conflicting elements take their proper places, and chaos begins to become a cosmos. The immediate cause of this transformation was a chance observation in Cullen's 'Materia Medica.' This gave him the clue to his discovery, just as the falling apple did to Newton, and the swinging chandelier in the church at Pisa to Galileo. From this observation it occurred to him that provings of drugs upon healthy persons might furnish a knowledge of their specific properties, and that the administration of drugs in cases presenting symptoms similar to those which the drug produces in the healthy subject might be the law of the application of specifics. That was his guess. He then, like a true man of science, proceeded to verify it. He first sought throughout the whole of medical literature of ancient and modern times for instances bearing upon this point, and he collected a large mass of evidence corroborating his speculations. He next proceeded to verify his theory by actual experiment.

"First upon himself, and then upon all healthy persons who would join him, he proved the effects of a number of drugs. Then, cautiously, first in his own family, and then little by little in general practice, which he had now resumed, he used those proved drugs in cases of disease that presented symp-

toms most similar to those produced by the drugs. This went on from 1790 to 1805, fifteen years of the prime of his life. He was now sure of the truth of his great principle, supported as it was with all the incidental testimony of history and the positive results of a long series of experiments. He therefore laid the whole matter before his colleagues, and adjured them in the name of truth and in the interest of humanity to investigate it candidly and without prejudice. 'If,' he says, 'experience should show you that my method is the best, then make use of it for the benefit of mankind, and give God the glory!' The reply to this was—*personal* abuse. 'Thou son of a porcelain painter, thou wast altogether born in sin, and dost thou teach us?' And they cast him out. That he was a humbug they thought was very probable, for the sincere alone can recognise sincerity; that he was a bore they were quite sure, for, like Socrates of old, he was always asking inconvenient questions.

"Of Hahnemann's attainments in the collateral science of chemistry we need not speak. In his tests for detecting iron and lead in wine, and distinguishing the one from the other, and in the preparation of 'soluble mercury' we discern the prophecy and promise of a great chemist, had not the science of healing claimed him for its own; but it is because of his greatest achievement, the creation of the science of therapeutics, that we specially remember him to-night. Homœopathy claims to be '*The Science of Therapeutics.*' This claim involves the startling assumption that prior to the establishment of homœopathy on a scientific basis by Hahnemann, therapeutics as a science had no existence. I would make the still further claim that apart from conscious or unconscious homœopathy, therapeutics as a science has no existence to-day.

"In looking at Hahnemann as a scientific man we note :—

"(1) *The man himself* :—

"(a) He was a learned man; now inspiration does not necessarily depend on learning, but inspiration usually comes where learning is.

"(b) He was an honest and sincere man in the widest acceptation of that word—honest and sincere in thought, word and deed.

"(c) He was studious and diligent in all he did, with an intense devotion to duty, even in his darkest hours.

"(d) The duty that lay nearest him was the providing of daily bread for his wife and family. It was in the doing of this

**Note of identification found in Hahnemann's grave, written by  
his Second Wife.**

**Monument in Pere Lachaise, Paris, erected 1900.**

1901



duty that he got the clue to his great discovery, in a chance observation of Cullen's.

“(2) *His scientific method* :—

“(a) The result of the chance observation was a *guess* on his part concerning the possible relation subsisting between the phenomena of drug-action on the one hand and the phenomena of natural disease on the other.

“(b) He collected a large mass of evidence corroborating his speculations from past and present medical literature.

“(c) He then proceeded to test and verify his theory by actual experiment. He devoted fifteen years to this work of verification, and made a large collection of experimental facts sufficient to convince any reasonable man of the truth of his theory. In his day it was customary in medical ‘science’ to content one’s self with a merely metaphysical, unverified interpretation of phenomena.

“(3) *The right of Homœopathy to be regarded as the Science of Therapeutics* :—

“(a) It is capable of infinite progress in each of its elements without detriment to its integrity as a whole.

“(b) It is able to provide for the prediction of future events within its own domain, *i.e.*, it teaches us *in advance* how to cure new and hitherto unknown diseases. An illustrious example of this *prevision*, this knowing in advance, was afforded by Hahnemann in the directions he gave for the treatment of Asiatic cholera on its first invasion of Europe.

“No other so-called ‘system’ of therapeutics in the world can fulfil these two conditions.

“In conclusion, we hail Hahnemann as a hero in an age when to be a hero was difficult—an age of scepticism and valet-souls, an age seething with quackery—quackery, indeed, regarded as the necessary vehicle of truth. Like Luther, he was one of Saxony’s noblest sons, and like him he was a great emancipator and idol-breaker. Sincere in heart, as all great men must be, he hated insincerity with a deadly hatred. He is remembered by us to-night, and will ever be remembered by posterity, as the Emancipator, the Messiah of Medicine, the creator of THE Science of Therapeutics.”

#### HAHNEMANN AS A SANITARY REFORMER.

Dr. Byres Moir delivered an oration as follows :—

“In referring to the work done by Hahnemann as a sanitary reformer, it is necessary first of all to explain that it is quite

evident from his writings that it was during the first half of his life that he was actively engaged in this direction, and that after the promulgation of his principles of drug treatment he became so absorbed in drug proving and the work of the *Materia Medica*, that he gave up writing directly on these topics, though in his letters to patients up to the last we find clear evidence of his laying down general directions with regard to diet, exercise, fresh air, &c., which could not be improved upon at the present time.

“In his lesser writings, the translations of which we owe to the late lamented Dr. Dudgeon, there are a series of articles collected under the title of ‘The Friend of Health,’ published in the years 1792 and 1795. The articles are sixteen in number, beginning with ‘The Bites of Mad Dogs’ and finishing with ‘The Choice of a Family Physician.’

“Though written 110 years ago, they are still full of interest, and many of them deal with important subjects which are attracting attention at the present time.

“For instance, we have just had a committee appointed to deal with the question of physical deterioration; they do not seem to have given a definite opinion, on the ground that they have not sufficient data to decide upon. It is interesting, therefore, to turn to Hahnemann’s article, ‘On Making the Body Hardy,’ in which there is this statement, that ‘in the centre of a great and populous city it is utterly impossible to bring up healthy children, and equally so to harden their frames.’ He dwells both upon the enervating effects of luxury, comparing the children to hothouse plants, and to the effects of poverty, associated with the deteriorated air, in closely built towns, with high houses, in the production of rickets and similar diseases.

“His ideal seemed to be towns of about 2,000 inhabitants, in which he says the houses should not be built higher than two storeys, with straight, broad streets, and gardens behind. In this we surely have the forethought of the ‘garden cities’ now proposed.

“In another direction, also of great interest at the present time, we may claim Hahnemann as one of the early pioneers; a subject which has been brought to the front by recent bacteriological work—that is, immunity to infectious or morbid processes. At the present time we see efforts made to attain this immunity by the inoculation of attenuated virus. In his article on ‘Protection against Infection in Epidemic Diseases,’ Hahnemann says, ‘That we may gradually accustom ourselves

to the most poisonous exhalations and remain pretty well in the midst of them.' This is to be obtained, in his words, 'by very gradually approaching and accustoming ourselves to the inflammatory material of the contagion, to blunt by degrees our nerves to the impression of the miasm, otherwise so easily communicable,' meaning that immunity can be obtained by frequent and small doses of the infection. He gives careful directions for visitors to the sick, doctors, and nurses how to conduct themselves in outbreaks of infectious disorders, and says that those who have already attended patients affected with the complaint are more secure from the infection than those who have not.

"After he had discovered the principle of 'like curing like,' he came to the conclusion that a medicine which causes symptoms similar to the disease must be one of the best preventives; arguing also in this case from the prophylactic action of cow-pox against small-pox, the cow-pox, he considered, constituting altogether a disease very like small-pox.

"From this came his recommendation of belladonna as a prophylactic in scarlet fever. This has, of course, met with much ridicule, but all that Hahnemann asked was that it should be put to the test, giving in detail his own results. A very different view of this can be taken now in the light of the work done in toxins and antitoxins, and the explanation which our Chairman gave us in his paper on 'Serum Therapy and its Relation to Homœopathy,' belladonna producing in the body an antitoxin which would be similar to that produced by the poison of scarlet fever.

"In the same way he recommended copper in cholera, both as a prophylactic and curative in the second stage, and we have plenty of evidence in the figures of the homœopathic treatment of cholera of the good results that followed this recommendation.

"Bearing upon this point, and the change of view that has taken place with regard to the action of small doses, I could not do better than refer to some articles which appeared in the *Daily Graphic* last month on 'Water Purification by Copper.' In this it is stated that 'to get rid of the green scum of water plants, such as algæ, the dilution required for such treatment need not be more than 1 part of copper sulphate to 8,000,000 parts of water. The dilution is so great that in order to obtain a medicinal dose of the chemical it would be necessary for an individual to drink about forty gallons of water a day.' We have here, gentlemen, the old view of the medicinal dose, and no reasons given why algæ should be considered to be more sensitive than the cells of the human

body. The correspondent was asked by several enquirers whether this destructive power of copper could not be turned to use in the treatment and prevention of typhoid and cholera. He says that he made enquiries in medical quarters, but could hold out no hope that the treatment could be applied to them. He evidently did not apply in the right quarter, and it shows how little is known of the work already done by homœopathy, and also that we have not followed as we ought to have done the lead which Hahnemann gave us in this direction.

"I have referred on previous occasions to what I consider the best and most up-to-date article on the question of public health that Hahnemann wrote, viz., 'On the Prevention of Epidemics,' and do not wish to weary you by repetition, but, as some here may not know of this work, I may briefly state that we find Hahnemann in 1795 recommending in three articles—'On Plans for Eradicating a Malignant Fever,' and 'Suggestions for the Prevention of Epidemics in General, Especially in Towns'—all the means which are in use at the present time, going into the most careful details, *i.e.* :—

"Strict rules for the isolation of cases in hospitals outside the city walls.

"Dresses to be worn by doctors and nurses, with directions for their disinfection—long before the presence of germs were known.

"That the police should be paid about 3s. 6d. for each case of infectious disease reported, thus suggesting the Notification Act which has recently been carried out in this country.

"Disinfection of clothes, &c., by dry heat in an oven taken up to a temperature of 120° Reaumur. Numerous directions for food, water, cleaning of cesspools, &c. The danger of public schools for the diffusion of contagion; attention has been again drawn to this of late as the chief cause of the spread of diphtheria in London.

"Hahnemann's own words are: 'If schoolmasters in general were given to attend more to the physical and moral training of their pupils than to cramming their memories, much mischief of this character might be prevented. It should be impressed upon them not to admit any sick child to the classes, whose altered appearance betrays the commencement of disease. Besides, a sick child can learn nothing.

"He recommends cremation for the disposal of the corpses. There are many other points, such as the care of prisons and lunatic asylums, which it would be interesting to dwell upon, but

I have given enough instances to show that he was much before his time. And we must remember that these articles were written simply from his sense of duty to the public well-being, and, as he says, by a private individual occupying no official post. What a medical officer of health he would have made !

“ Wherever we turn in his writings on the question of health, we find matter which appeals to us and holds good for all time. Each of us looks at it from some different point, but all will find some point that comes directly home.

“ In my own case I found a teacher after my own heart in the directions which he gave to a young man who wrote to him about his health. He asks him how he can expect to keep well if he did not take proper exercise, and that it was his duty to be out walking for at least an hour every day, whatever the weather, and as well he was to fence for half an hour, using first one arm and then the other, leaving the question of medicine till after he had given the most careful regimen.

“ Dr. Roberson Day, who has just brought out his work on Children, would, I am sure, approve of his teaching in the care of children which he gives under the title of ‘ A Nursery.’

“ A few years ago Dr. Burwood gave us a most interesting and original paper from his own observations on the effect of altered barometric pressure; it is therefore interesting to find Hahnemann referring to the influence of climate, weather, state of barometer, &c., and noticing especially the effect of a low state of the barometer on the apoplectic.

“ I am afraid I must accuse Hahnemann of one great inconsistency ; it is, in fact, a case of ‘ compounding for sins he was inclined to, by damning those he had no mind to,’ for while we find over twenty pages devoted to the bad effect of coffee (in this country it would have been tea), I find no mention of tobacco. The reason is obvious, for Hahnemann was an inveterate smoker, seldom being seen without his long pipe. In our present atmosphere it is better perhaps not to dwell upon this, which we may consider his one redeeming vice.

“ I am sorry to have dealt so inadequately with my subject, and must ask your leniency for treating it so superficially. Hahnemann not only taught, but put in practice in his own life, that health was to be obtained by fresh air, cold water, exercise, moderation in diet, enthusiasm in work, and a contented mind. As a result he remained actively at work and clear in brain power up to the end of his life at the ripe age of 89.”

Dr. Cartier at this moment rose and said :—

“Gentlemen,—Some nine years ago I had the pleasure of being present among you at the same Cecil Hotel for your brilliant International Homœopathic Congress. To-day I am happy to find myself in this hall among my English colleagues, whose value we appreciate so highly in France by their books and writings.

“In the name of the French Homœopathic Society I am desired to offer to the British Homœopathic Society the feelings of our warmest sympathy.

“This evening I have the opportunity of announcing to you some good news coming from France ; a very high personage of the French Republic has had recourse to homœopathy for his son, who is in a good way of recovery. I hope that that news will be pleasant for you, for the *entente cordiale* does not exist only between our two Governments. The *entente cordiale* has always been in existence between the homœopathic physicians of both countries ; so I toast the Union and Prosperity of our two Societies.”

#### HAHNEMANN AS PHILOSOPHER AND MAN OF LETTERS.

Dr. George Burford, in eloquent tones, gave the following oration :—

“To-night we have had raised for us the curtain of the eighteenth century, and have seen the central figure of homœopathy as he lived and moved in that strenuous time. To-night we have had the historian’s light turned on this epoch-making personality, first as man and citizen, then as hygienist and sanitary reformer, again as scientific discoverer, and now it is my duty to present him as original thinker and man of letters.

“A great cause needs a great personality quite as much as a great principle. How many good causes, political and other, have had their clock put back by defaulting leaders? We in homœopathy have been particularly fortunate in great and distinctive personalities. In this country alone we may particularise Dudgeon and Hughes, present with us at the last Hahnemann Dinner ; Drysdale, Rutherford Russell, and Quin of the old guard—all names and personalities of distinction and renown. But captain and chief of them all stands Samuel Hahnemann, the perpetual President of every homœopathic society and of every homœopathic meeting throughout the world, to whose

memory and to whose good works we are met to pay homage to-night.

“Now my contribution to the symposium is to make vivid the life-history of Hahnemann as a philosopher and man of letters. Hahnemann's work as a philosopher requires some definition of the title. Time was, not so very long ago, when *anything* pertaining to knowledge was called philosophical; we had philosophical institutes by the score, and a barometer was called a philosophical instrument, and so also was a galvanic battery. The most curious survival of this is in the case of the Royal Society—an august and rigidly scientific body—which styles the record of its proceedings philosophical transactions. But we do not call this material philosophy nowadays: we call it science. On the other hand, there are certain dryasdusts who deal solemnly with cosmological conceptions and ontological ideas, and whose talk is, as Carlyle said of Coleridge, mostly of the subjective and the objective. Well, Hahnemann contributed little to the cosmological conception or the ontological idea. But his part and lot in philosophy was of another type. Implicit and collateral, rather than direct and immediate, his contributions to philosophy involved questions of primary importance. Two specimens shall suffice. One of the first functions of philosophy is logic, and Hahnemann, in employing a strict logical process, contributed materially to the unifying work of philosophy as harmonising human knowledge. Dr. Whewell tells us that why the Greeks failed in the advancement of knowledge was because their conceptions were not appropriate to the facts of the case. Now, the actual observation and repeated verification of the facts of the case we call science, and it is laboratory work. But the perception of the meaning of things and the simplification of the problems of existence we may include under philosophy, and this is library work. And this part of philosophy was the one which corresponds to Hahnemann's philosophical work.

“Now, Hahnemann adopted an entirely true method for getting at the facts of Nature. He deliberately chose that form of logic called the deductive process for his special class of work. Up to his time the method had not been *seen* to be the only true and reliable instrument for getting at Nature's meanings in medical matters. All kinds of substitutes had been devised and used for getting at these secrets of Nature about the cure of disease. Hahnemann's genius *saw* that the whole must be divested of complications, which are food to the quibbler. Take remedies,



said he ; give them in health—the pure, uncomplicated state—see what they do, and you have a certain guide to their powers when one is sick. Now, some investigators give new remedies to persons who are sick, and draw their conclusions from the medley which follows. Others observe what happens with and what happens without the giving of a certain remedy in a certain kind of case, and then draw their conclusions as to its value. Hahnemann simplified the problem, eliminated the cross-currents of disease, and noted down the pure and uncomplicated symptoms following drug-giving in a healthy body. Here, said he, is the clear account of the powers of the remedy. And this is the strict homœopathic plan of trying or proving remedies.

“So matters went on, till in the Victorian era there arose two massive logicians, John Stuart Mill and Alexander Bain. Both were struck with the sterility of non-homœopathic methods, and scanned with critical eyes the causes of the apparent arrest in progress. Bain criticised the apparent inability of medicine to get beyond empiricism—that is, that a remedy is ‘good for’ a complaint, with no explanation of the reason. Until you do better than this, in substance he said, your progress must of necessity be very limited.

“Mill’s acumen went farther. He discussed the cause of the slow progress in medicine, and went carefully into the available methods of discovery. One common method he dismisses at once as giving ‘no conclusions of value.’ Another specified method he says ‘is in these complicated cases out of the question.’ And both he dismisses as ‘from the very nature of the case inefficient and illusory.’

“Mill, however, goes farther. The proper method, said he, is the deductive method. ‘If we try experiments on a person in health to ascertain the laws of the action of a drug, and then reason therefrom how it will act in a particular disease, this may be a really effective method—and this is deduction.’ Could any words more aptly describe the process of Hahnemann—devised by him before logic had justified the plan? Mill, after surveying the field, enumerates the difficulties in enquiry, dismisses certain favourite methods as unsound, specifies and elaborates one method as peculiarly, or, as he calls it, ‘naturally,’ fitting. And this, gentlemen, is exactly and precisely the method chosen and selected by Hahnemann for determining the curative power of remedies.

“This is the chief, but not by any means the only important issue of Hahnemann’s philosophic frame of mind. To know the



meaning of things was his desire. His receptive mind had assimilated the trend of philosophic thought of the day, and his main doctrine, a scientific one, received certain collateral support from current philosophical views. His observations and reflections led him to regard a vital force as the source of all the phenomena of life. Apart from the mere limitation of ideas due to the limited knowledge of his time, it is remarkable how again this doctrine of vitalism has come uppermost. In the last century it was thought to have been pulverised, smashed, and destroyed. Tyndall fulminated against it: 'I see in matter,' said he, 'the promise and potency of life.' Huxley was no less emphatic and definite in his own lucid style.

"But the whirligig of time brings about its revenge; and now we have Sir J. Crichton-Browne saying, 'Physiology has in its materialistic fervour vaunted itself as having banished vitalism. In 1889 Sir J. B. Sanderson declared that the word vital as distinctive of physiological processes must now be abandoned altogether; but in view of recent researches I question if he would to-day repeat that statement.'

"So much for Hahnemann as a philosopher.

"Hahnemann was not only a man of science, but a man of letters. I do not mean he was a poet, or a literary critic, or a novelist, or a historian; but he was a scholar, and an essayist, and a linguist, and a journalist. His favourite residual occupation in earlier life was in translating text-books and essays from English into German; we all know that the first germ of homœopathy sprang up during the translation of Cullen's 'Materia Medica.' From the French he translated, besides other books, a work issued by the Academy on the Art of Manufacturing Chemical Products. Add to these languages a mastership of Italian and Spanish, and it is evident how vast a range of contemporary literature lay at his command.

"Hahnemann was no mere linguist: he was a scholar also. Classical literature, whether Greek, or Latin, or even Arabic, bulked largely in his intellectual equipment. As a small boy of twelve he was engaged to teach the rudiments of Greek to his fellows. Haller's 'Materia Medica' he translated from the Latin, and his Latin thesis was 'On the Construction of the Human Hand.' His intimate acquaintance with Arabic is evident from the quotations in his thesis on the 'Hellebore of the Ancients'; and it is no wonder that Jean Paul Richter described him as 'Hahnemann, that prodigy of philosophy and erudition.'

"All this must largely have contributed to the lucid and

flexible style which have made his German works so easy to follow. His German writings are voluminous; but in the classical productions—the *Organon*, the *Materia Medica Pura*, the *Chronic Diseases*—while the various editions of these have been examined, compared and collated throughout, there are no disputed passages, there are no locutions of doubtful interpretation. It is not necessary to hunt up First Folios to get rid of an impure text; and, least of all, to search for acrostics or anagrams in his capital letters or paragraph headings, which, judiciously arranged, would signify ‘Samuel Hahnemann, his Book’!

“I have said Hahnemann was a scholar, and from all aspects of such an all-round, full-orbed culture he stands well furnished and complete. Add to the foregoing detail that early in life he classified and arranged a ‘matchless collection of ancient coins’ for a Grand Seigneur, and catalogued a great private library of books and rare manuscripts for the same Mæcenæ, and we have to re-echo Richter’s summary of him as ‘that prodigy of philosophy and erudition.’

“Hahnemann, like all literary men of note, found irresistible attraction in the society and life of the great seats of learning; Leipzig, Dresden, and Paris successively opened their doors to him, and his intellectual acquirements and professional scholarship were undisputed. At Paris we find the great minister Guizot referring to him thus: ‘Hahnemann,’ said Guizot, ‘is a scholar of great merit.’ The picture of Hahnemann’s life at Leipzig is well delineated by Baron Von Brunnov, and very forcibly reminds us of that vivid description by William Hepworth Dixon of the early life of another great German, Immanuel Kant, at Königsberg.

“Besides translations, which were pretty numerous, and monographs on chemical subjects, such as arsenical poisoning and his new preparation of mercury, a veritable stream of medical works issued from his pen. Text-books and classics of homœopathic literature (stout, solid volumes of the German sort), essays on special subjects by the score, dissertations, pamphlets, all taken together, form a very respectable library of their own, not counting various editions with additions and alterations of the text. I have counted in his bibliography 114 separate works, from the five-volume text-book to the three-volume dictionary, the single volume translation, the 80-100 page dissertation, the fifteen page essay.

“I cannot leave this literary conspectus without alluding to Hahnemann’s power as a controversialist. Verily he did not

believe in making even literary war with kid gloves. With him the conduct of warfare was the conduct of warfare. He did not leave his opponent until he had pulverised, smashed, and destroyed him; and, to slightly change a phrase, whom he would he slew, and whom he would he flayed alive. It was part of the literary amenities of those days; controversialists went for each other with a real Berserker spirit, thirsting for gore. Those who wish to see a specimen *in excelsis* will find it in the battle royal between Salmasius, Professor at the University of Leyden, and our own John Milton, where these two world-renowned writers banged each other with the licence of dock labourers. Echoes have come down to our own day, for we have excellent specimens of denunciatory controversy in Ruskin and again in Carlyle. It was, I say, the spirit of the times, and so when Hahnemann enters the lists in what appears a truculent mood, it must be remembered that he was scarcely living up to more illustrious example, and that a man who was hailed by his opponents as a murderer, a charlatan, and other flowers of rhetoric, could scarcely be expected to take it lying.

"Finally, Hahnemann, like all men of genius, was not infallible. That the system was greater than the man none would have been more quick to avow. This is the work of all interpreters of Nature, that they go back to Nature again and again for verification or correction, and put it in the way of others to do the same. Possibly Hahnemann did not, like Mill, actually 'solicit contrary impressions,' but he weighed the reasonable criticisms of his opponents, and rectified his statements according to the evidence open to him. He contributed a large mass of new facts to the world's knowledge, and thus left it to his followers to unceasingly compare the facts with the original, and in the same spirit to alter and amplify where necessary, ever adhering closely to the book of Nature.

"In this review of Hahnemann as a philosopher and a man of letters I fear that I have drifted into the style of a lay sermon. When I commenced my exercitation there was in my mind the injunction of the Apocrypha, 'Let us now praise famous men.' I trust that I have sufficiently justified Hahnemann's position as a famous man, and therefore both you and I may well feel called upon to yield him an unstinted meed of praise."

During the evening a number of interesting relics of Hahnemann were on view.

Greetings were also sent by Dr. W. Schwabe, of Leipzig,

who kindly lent for exhibition, among the relics, two of Hahnemann's medicine cases, with remedies prepared by his own hand, and some of the MS. of the *Reine artz-mittellehre*; and by M. Ladislas Pietrozynski, of Paris, who kindly lent a plaster cast of Hahnemann's hand, given to him by Madame Hahnemann, and a photograph of Hahnemann's tomb in Pere Lachaise Cemetery.

The company separated at 11.30 p.m.

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**SOCIETY NEWS.****NEW FELLOWS.**

At the meeting on June 1, Frank A. Watkins, M.R.C.S., L.R.C.P., L.S.A., Pathologist to the London Homœopathic Hospital, elected member in 1895, was elected a Fellow of the Society.

At the meeting on June 28, Clement John Wilkinson, M.R.C.S., L.S.A., elected member in 1892, was elected a Fellow of the Society.

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**OBITUARY.**

*George John Lough, L.R.C.P.I., L.M.*

THE death from drowning in Ireland of Dr. Lough, late of Hastings, has been announced as having occurred on March 30 last. Dr. Lough was elected a member of the Society in 1891. He was not often seen at the meetings, nor had he contributed to the proceedings, but was well known as a good practitioner, and agreeable colleague. He had retired from practice for some time owing to ill-health.

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## SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

*Extracted from Exchange Journals by the Editor, in collaboration with J. Galley Blackley, M.B., and T. G. Stonham, M.D.*

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**Acetone in Typhoid Fever.**—Acetozone or benzoyl-acetyl-peroxide is a compound of peroxide of hydrogen, but possessing greater germicidal power. It is soluble in 1—1,000 of water, and in solution undergoes hydrolysis, splitting up into various peroxides, one of which, acetyl hydrogen peroxide, is an active germicidal agent. Acetozone is germicidal in the strength of 1 to 33,000, and has the advantage of being non-poisonous and harmless to mucous membranes even when in a saturated solution. Professors Novy and Freel report having fed students on milk and acetozone for several days, and during the whole time the fæces were sterile and the men quite healthy. It has therefore been used in typhoid fever as an intestinal germicide and antiseptic, and it is claimed that the fæces are completely deodorised in twenty-four hours, the diarrhoea ceases, the patient greatly improved, with shortening of the disease and the prevention of relapses. To administer it a saturated solution should be made by dissolving 15 grains in a quart of water at 90°; it should be vigorously stirred for a few minutes and then allowed to stand for two hours for hydrolysis to take place. This solution should be taken in divided doses during the twenty-four hours, given on as empty a stomach as possible. (Dr. W. W. Ross in *American Physician*, March 18, 1905.)—T. G. S.

**Arum Dracontium in Cough.**—Annie A., aged 4 years, had a loose cough, tracheal or laryngeal in origin, < at night on lying down; very little during the day. Little sleep at night on account of cough. This cough resembled the Pulsatilla cough, in coming on at night and in being worse on lying down, but different from it in being loose instead of dry. Arum dracontium 200, one dose was given, which enabled the child to sleep all the

next night and cured promptly. (Dr. R. P. Rabes, *Chironian*, February, 1905.)—T. G. S.

**Cactus Grand. in Influenza.**—Mr. C. K., aged 50, had been ill a week with influenza. Temperature 103·6°, pulse 100, rather weak. He was a large man, over-weighted, accustomed to drinking one or two pints of beer daily. Numerous sonorous and sibilant râles with some bubbling râles over chest. Heart dulness extends to the left as far as the mammary line. Impulse not to be felt. Slight reduplication of heart sounds. No murmur. A dry, harsh cough causing pain in the forehead and eyes, face flushed. A few days ago complained of a sensation as if a band were fastened about the upper part of chest, gone now. Very thirsty. Mouth dry, tongue coated yellow; calves of legs very heavy. Coldness of back between the scapulæ; smothered feeling of heart when turning on the left side. Small amount of dirty, yellowish, thick expectoration. Cactus grand. 900 in water every three hours, till four doses had been taken. The following morning temperature was 101° and pulse 88, and general condition improved. The morning after, temperature 98° and pulse 80; a return of palpitation when turning on left side and a feeling as though the heart were grasped or compressed. Cactus cm. one dose completed the cure. (Dr. Rabes, *Chironian*, February, 1905.)—T. G. S.

**Hamamelis.**—Dr. A. A. Ramsayer draws attention to an indication for the use of hamamelis in external injuries. He quotes Gilchrist, as pointing out that the effusion is entirely hæmorrhagic and remains fluid. The part is fluctuating, red in colour, and there is no disposition to coagulation (in contradistinction to arnica, which is called for when the hæmorrhagic swelling is firm and coagulation rapid; it removes the clots of blood). The characteristic effusion, which remains fluid, belongs mostly to injuries to the eye. Dr. Ramsayer instances two severe cases of this kind, in which the internal use of hamamelis 3, and its application topically appeared to act very promptly and were followed by recovery of vision without after impairment. (*Homœopathic Recorder*, May, p. 216.)—Ed.

**Helleborus Niger. Poisoning by Seeds.**—Ernst Fürth relates the following case, which was admitted to the Municipal Hospital of Dervent (Bosnia). A boy of 15, out of bravado, ate the contents of three nearly ripe seed capsules. He noticed at once acute burning on the tongue as if from eating pepper-

corns. Shortly afterwards pains in the head, slight buzzing in the ears and vertigo came on. After this he felt scraping and gagging in pharynx and œsophagus. In somewhat less than two hours after this the patient was brought under treatment; the heart-beat was strong, the pulse full and very tense, 60 in the minute, with very slight arrhythmia. The sensorium was slightly involved; now and then the patient made a few involuntary movements, the pupils were dilated and reaction was somewhat slow. The stomach was at once washed out with plain luke-warm water, and the washings showed numerous particles consisting of partially masticated seeds. A high irrigation of the lower bowel was followed by a copious stool, which, however, contained nothing abnormal; 1·2 gramme of ipecacuanha in powder was also administered, and produced copious emesis; in the vomit were numerous seeds and remains of such. Two hours later the pulse had risen to 74, felt less hard and was quite regular. The patient was still somnolent and slept continuously for fully ten hours. Next day the unpleasant symptoms had still further diminished; the pulse was about normal, 80 to 84 beats in the minute; pupils were still dilated, but had contracted since the day before, and reacted promptly; headache was still present, and the patient complained of burning thirst which was only allayed by plentiful doses of emulsion of almonds. In the course of the day spontaneous action of the bowels occurred, but nothing abnormal was detected in the fæces. The patient slept several times during the day for periods varying from half an hour to one hour, and again all night through for ten hours continuously. On the third day no change in the vascular system could be detected; headache was much less, the pupils were approximately normal, the sensorium quite free and the thirst was much less. It was only on the sixth day that the patient could be said to have completely recovered, for on the preceding days there was still headache, though not continuously. An increase of the tendon reflexes was observed on the first two days. So far as could be calculated, the quantity of seeds ingested lay somewhere between 40 and 70 centigrammes. (*Zeitschr. des Berl. Vereins hom. Aerzte*, April, 1905, p. 124.)—J. G. B.

**Hydrocyanic Acid in Acute Epileptic Seizures.** — Drs. Burford and Madden report a case which illustrates the precise sphere and value of hydrocyanic acid in convulsive states. It was that of a woman, aged 44, who had undergone abdominal section for pelvic disease, and a ute epileptic convulsions ensued



on the evening of the fifth day after operation. The convulsions were very acute and were succeeded by recurrence eight times on the following day, followed by very rapid pulse (160 per minute), and threatened death from collapse. Glonoine, belladonna and ignatia were tried first, apparently without effect. While in an unconscious state, with dilated pupils and upturned eyes, a pulse as above noted, a general state of collapse with threatened death, hydrocyanic acid 2x in three-drop doses every two hours was given. There was no recurrence of the fits, and, although the patient was very weak for a few days, recovery ensued. (*Monthly Homœopathic Review*, April, p. 209.)—ED.

**Justicia Adhatoda.**—Dr. S. C. Ghose, of Calcutta, has added another to the list of homœopathic remedies for diseases of the respiratory organs. He publishes two provings of *justicia adhatoda*, an Indian shrub, conducted by himself, and gives several cases in which the drug was administered. Of the provings, three-drop doses were given to two men, aged 32 and 27 respectively. In both cases the effects were observable on the second day, symptoms of coryza developing themselves and afterwards all the evidences of bronchial catarrh. The following schema summary is afforded of the symptoms observed: *Mind*—Anxiety, discouragement, irritability. *Head*—Fulness, heaviness, pressure in forehead, heat, pulsation both sides of forehead. *Eyes*—Lachrymation and burning pain. *Nose*—Coryza, swelling, sensitiveness and obstruction, sometimes dryness. *Face*—Hot, red and burning, > pressure. *Teeth*—Shooting pains extending to the cheek. *Mouth*—Dryness, with thirst. *Tongue*—White. *Throat*—Dryness, tenacious mucus. *Appetite and Stomach*—Loss of appetite, taste insipid and putrid, nausea, vomiting of mucus while coughing. *Abdomen*—Shooting and gnawing in hepatic region, flatus, gurgling. *Stool*—Loose, mixed with mucus, slight colic, > after stool. *Respiratory Organs*—Hoarseness, cough and rattling in the chest, tenderness of the larynx when touched, frequent fits of coughing, suffocation, sometimes with vomiting or sneezing, stitches at the chest and red face, sometimes expectoration of blood, slimy or tough yellowish mucus. *Generalities*—Over-sensitiveness to external impressions, raised temperature, chilly now and then. The cases recorded by Dr. Ghose, in which the drug has been administered as a remedy, include whooping cough, bronchitis, broncho-pneumonia, phthisis, coryza, and a liver case, the dose being in the 3x dilution down to the mother tincture. (*Homœopathic Recorder*, May, p. 193.)—ED.

**Tabacum in Sick Headache.**—A lady, aged 30, of lymphatic temperament, always subject to periodical sick headaches, lasting one or two days, and generally brought on by fatigue or excitement. The present paroxysm was more severe than any she had ever had. The pain was intense and agonising, at times seeming as if the head would burst, and again, as though the brain was being bored out. She sought continually to hide her head in the pillow, or to change it to a position that might relieve. Faintness, nausea and vomiting of all that had been eaten, and painful retching to vomit small quantities of mucus and bile; skin pale and cool, with clammy perspiration, breathing oppressed and laboured, countenance sunken and anxious. Tabacum 2 was given at half-hourly intervals. After the third dose complete relief was obtained. No paroxysm has since occurred (two months). (*American Physician*, March, 1905.)—T. G. S.

**Zizia Aurea in Chorea.**—Dr. U. A. Shautts relates the case of a girl, aged 16, tall, thin, pale, anæmic, poorly nourished. Chorea movements of arms and at times of legs, but the face muscles were those chiefly affected, sometimes those of the eyes and forehead, and sometimes those of the lower part of the face, when a condition ensued resembling risus sardonicus. The movements often continued during sleep. Zizia aurea was given (dose not stated) and improvement was perceptible in twenty-four hours, and recovery took place in a few weeks. (*American Physician*, March, 1905.)—T. G. S.

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*From Photo by Lizzie Caswall Smith, 309, Oxford Street, W*

**ROBERT ELLIS DUDGEON, M.D.,**

*President of the British Homœopathic Society, 1879.*

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*A communication and contribution to science*

Dr. GOLDSTON, 82, Wimpole Street, London, W.

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A NOTE ON THE THERAPEUTICS OF GASTRIC  
ULCER.<sup>1</sup>

BY CLEMENT JOHN WILKINSON, M.R.C.S.D., L.S.A.

MR. PRESIDENT,—I have called my present communication “a note upon the therapeutics of ulcer of the stomach” because I was anxious to avoid the suggestion that I contemplate anything approaching a systematic handling of the whole subject. Twenty years ago, the late Dr. Bristowe devoted four pages of his “Theory and Practice of Medicine” to a chapter for the discussion of this disease. To-day, thanks in great measure to the intervention of surgery, our knowledge on the subject has extended both in scope and accuracy; its bibliography is immense; and the views on its causation, pathology and treatment are rapidly convergent. Had the literature of this subject been complete, it could be summarised at length in a single chapter of a field in one part. The work of the homoeopaths, however, is only a small corner of it. But with this I am content to deal, a partial

<sup>1</sup> Presented to the Section of Materia Medica, 11th day 1, 1905.

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*All communications and exchanges to be sent to*  
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MR. PRESIDENT,—I have called my present communication “a note upon the therapeutics of ulcer of the stomach” because I was anxious to avoid the suggestion that I contemplate anything approaching a systematic handling of the whole subject. Twenty years ago, the late Dr. Bristowe found four pages of his “Theory and Practice of Medicine” sufficient for the discussion of this disease. To-day, thanks in part to the intervention of surgery, our knowledge on the subject has extended both in scope and accuracy; its bibliography is immense; and the views held concerning causation, pathology and treatment are widely divergent. Had I the necessary qualifications, no useful purpose could be served by an attempt to comprehend this vast field in one paper. The task which I have set myself covers only a small corner of it. But while I limit myself to a partial

<sup>1</sup> Presented to the Section of Materia Medica and Therapeutics, May 4, 1905.

examination of the phenomena of the disease and a consideration of the degree of fulness with which our pharmacodynamics correspond to those phenomena, there is no reason why the discussion which follows should be subject to the same limitations.

One has not considered the causation of gastric ulcer for long before he is driven to conclude that the causes are both many and complex—that is to say, that there are many causes which may induce the ulceration, and that any given case of ulcer is probably the result of several contributory causes. It seems likely that the hyperacidity of the gastric juice, which is sometimes found in such cases, is rather a consequence than a cause of the diseased condition; for (1) ulceration is by no means a constant occurrence where hyperacidity is found; (2) it is difficult to understand why acute ulcer is very frequently single, and why it should most frequently occur on the lesser curvature, and, by preference, near the cardiac end of the stomach, if due to a cause liable to affect the whole mucous surface of the stomach generally, and that particular region less than most. But I find myself unable to construct a theory of causation which does not include digestion by the gastric juice of localised areas of necrosed mucous membrane, such digestion depending upon the devitalised state of the mucous membrane rather than upon any unusual digestive power of the juice. My interest, then, centres itself upon those causes which bring about localised necrosis.

There is one of such causes to which I wish to draw particular attention; in part because, by reason of its comparatively recent discovery, the importance of it has not yet attained general recognition; but chiefly because it is a factor in causation, which has a possible bearing upon the therapeutics of the disease, and a definite bearing upon prevention and general treatment.

The secretory function of the glands in the gastrointestinal mucous membrane is so constantly forced upon our attention that we may be forgiven for forgetting that they also possess powers of elimination. But the fact that



they do so has long been known. They will, when more ordinary excretory channels are in partial or complete abeyance, filter such substances as the following from the blood supplied to them, and discharge them into the cavity of the stomach—derivatives of opium,<sup>1</sup> including apomorphia and probably oxidymorphine, a large number of other alkalis, salts of iron, magnesium, lithium, strontium and antimony, cantharidin, iodide of potassium, and urea.<sup>2</sup> The Fenwicks, father and son, discovered that the frequent subcutaneous injection of urea was apt to be followed by acute inflammation of the gastro-intestinal mucous membrane, and Aufrect has found that cantharidin similarly used acts in similar fashion, a point of analogy, parenthetically, which cannot but interest us as bearing upon our use of cantharides in uræmic conditions. We may regard it as established, then, that this eliminative or excretory function of the gastro-intestinal glands is not only highly selective as to the materials with which it deals, but that it is strictly limited as to its power in regard even of them, and that overwork of those glands in the excretion of some of those materials is followed by acute inflammation of the mucous membrane in which the glands are placed.

Another experiment<sup>3</sup> of the Fenwicks justifies us in going a step farther. They extracted from the sloughs of burnt skin a small quantity of an albumose, which, injected into both cats and rabbits, induced an appreciable degree of duodenitis in both classes of animals. As cantharidin and urea produce inflammation of both the gastric and intestinal mucous membrane, whereas the Fenwick albumose influences that of the duodenum only, a region notoriously prone to ulceration as a sequel to extensive burning of the skin, we may justly infer that there is selection as between the substances excreted by the glands of the stomach and duodenum, that the poisons of auto-intoxication are among those which these glands will excrete, and that the inflam-

<sup>1</sup> Sir Lauder Brunton. "The Action of Medicines," Ed. 1897, p. 640.

<sup>2</sup> Fenwick. "Ulcer of the Stomach and Duodenum," p. 111. It should be noted that *cannot* on p. 112 is a clerical error for *can*.

<sup>3</sup> *Ibid.*, p. 112.

mation set up by overwork of this function is one which, pushed far enough, is prone to terminate in ulceration.

Having established that the poisons of auto-intoxication are capable of setting up ulceration of the stomach and duodenum, we naturally pass on to consider which of the many possible auto-intoxications are commonly present in cases of such ulceration. I have, unfortunately, no figures to emphasise my observation, but I have no doubt that your collective experience will endorse my individual experience that the cases of gastric ulcer in which oral sepsis or habitual constipation (and commonly both) are absent are so few in number as to be a negligible quantity in a consideration of the typical and average case.

By oral sepsis, of course, I do not mean simply the presence of one or more carious teeth; this is a condition of things doubtless responsible for many varieties of dyspepsia, and it may well be that it plays a preparatory part in lessening the resistance of the mucous membrane to the deeper causes which will follow it if not properly dealt with. Oral sepsis in its fully developed condition is a very much more serious matter, supported by the presence of old stumps surrounded in the gum by ulceration and granulation, bedded in a chronic abscess discharging constantly by fistulous openings through the alveolar plates of the maxilla. Pus and the results of bacterial life thus encouraged, mingle with the saliva, are absorbed by the stomach and intestines, circulate with the blood, inducing hæmolytic changes, and are, I think, without doubt responsible for the extreme grades of anæmia which we associate commonly with ulcer of the stomach. It seems more than probable that the elimination of toxic albumoses, resulting from the action of oral septics on the blood, is a tax beyond the power of whatever may be the organs devoted to that end, that the peptic glands, among other such organs, should suffer from overwork, inflammation of their substance and surroundings, and that ultimately necrosis should be set up, to be followed speedily by the digestion of the necrosed area and the formation of an ulcer.

Not very different, I take it, is the method by which

habitual colonic constipation achieves a similar pathological result. It is not the mere delayed discharge of fæces from the large intestine which induces gastric ulcer; else it were an even commoner disease than we know it to be. I refer rather to that condition of the colon in which "fæcal masses are lodged in the colon, fill up the sacculi and tend to become nodular in consequence. They harden by absorption of their fluid contents, and may attain very considerable dimensions. They are met with most usually in the cæcum or sigmoid flexure, or in the transverse colon. The bowel containing them is apt to become ulcerated, partly from pressure and partly from the chemical irritation of the highly decomposed mass. The ulcers are most common in the cæcum, because it is upon that part of the colon that the greatest strain comes in fæcal accumulation. They are called 'stercoral ulcers,'<sup>1</sup> and may be both numerous and extensive."

Such a condition is dangerous both from its direct and its indirect effects. Directly it is an occasional, though not a common cause of perforation; indirectly it is responsible for a vast amount of mental and bodily suffering. It is, moreover, a treacherous condition, easily overlooked primarily (for there are many more cases of impacted fæces than are detected by even careful palpation), and apt to occur insidiously even while a watch is being kept for its occurrence. This was well illustrated for me by an old gentleman of 80 years who had cerebral softening, and developed fæcal impaction while his bowels acted apparently well day by day. The difficulty of removing the hardened masses from the rectum was so great that an anæsthetic was necessary; and one naturally determined to watch very carefully. None the less, on three several occasions impaction took place in spite of a daily inspection of the motions, and sooner or later its piecemeal removal from the rectum was imperative. This trouble arises from nuclei of impactions forming in the dilated sacculi and gradually increasing by agglomeration, while the greater amount of fæces passes the mouths of the sacculi unimpeded.

<sup>1</sup> Sir F. Treves, Clifford Allbutt's "System of Medicine," vol. iii., p. 836.

Abdominal massage is helpful in such cases. In the young, exercises which consist essentially in lying on the back with the arms behind the head (to fix the lower ribs) while the legs are held stiff and flexed on the trunk, are very effectual.

How considerable is the amount of absorption by the large intestine may be gathered from the following statement of Sir Lauder Brunton: "If a healthy man is obliged to pass over a day without evacuating the bowels, the movement on a succeeding day is likely to be not only drier and harder than usual, but frequently more scanty. . . . the absorption being greater, there is less (instead of more) residue to evacuate."<sup>1</sup> If, then, an extra twenty-four hours is sufficient to halve the bulk of a day's accumulation, what must be the ratio of absorption in these masses retained for many weeks in dilated colonic sacculi? and what must be the degree of toxicity in the matter absorbed when, in addition to its own decomposition, we predicate the presence of sloughing intestinal mucous membrane, and an ulcerous base bathed in toxins and autotoxins?

That such an intake should overtax the ordinary excretory apparatus is obvious. When it is recognised that certain autotoxins are excreted by the peptic glands, that excretory overwork of the peptic glands is a factor in the production of ulcer, and that habitual colonic constipation is closely associated with chlorosis and ulcer, it is no long step in deduction to arrive at the conclusion that the autotoxin of this intestinal absorption is a highly probable contributory cause to ulceration.

The recognition of the place of oral sepsis and of colonic constipation in the etiology of ulcer involves the immediate treatment of those conditions when they are found in association with symptoms suggestive of ulceration. I have seen not a few cases in which vomiting, localised epigastric pain, aggravated by the presence of food in the stomach (such pain "going through to the back," as patients describe it, and being often relieved temporarily by posture), have speedily improved upon attention being paid to the mouth, or the action of the bowels being systematically regulated.

<sup>1</sup> *Ibid*, vol. iii., p. 700.

And I think that it cannot be too clearly appreciated that in a chlorotic patient the symptoms which I have mentioned justify a practical presumption of the presence of an ulcer. To await hæmatemesis or melæna before taking steps is scarcely far-seeing: and it is well to bear in mind that perforation and not hæmorrhage may be the first occurrence that will clinch a delayed diagnosis. I have found several times that in the presence of epigastric pain and vomiting it is well to enquire for a sudden momentary loss of sight and giving way of the knees. The significance of such symptoms does not occur to the patient, and the symptoms are therefore very likely to be left out of her story; but when they are given in response to a question, and the occurrence of a black offensive stool is also acknowledged, the presumption of hæmorrhage is very strong, and the diagnosis of ulcer is proportionately certified.

In the face of the evidence that the excessive excretion of autotoxins by the peptic glands is a cause of ulcer, it is greatly to be wished that we had more thorough knowledge as to what drugs are excreted in the same manner, for similarity in this matter would clearly be helpful in the selection of the similitum, other things being equal.

The second point upon which I wish to hang a few remarks of therapeutic bearing is the fact that the stomach proper is without any nerves of sensation. This is demonstrably true, though it contraverts the experiences alike of "the infant mewling and puking in the nurse's arms" and of man "in the last scene of all that ends this strange, eventful history," when he is "sans teeth, sans eyes, sans taste, sans everything," except the rooted conviction that he has "a pain in his stomach." Operations upon the stomach, undertaken under the conditions of local anæsthesia of the abdominal wall, have proved that there is no outrage to the sensibility of the normal stomach proper, which that organ will resent by the occurrence of pain. The innervation of the gastric musculature is a complex question, but, whatever view may be taken of the part played by the vagi or the splanchnic nerves in promoting and regulating the highly co-ordinated movements of the

stomach, we cannot regard either of these as nerves of sensation, and we have to fall back upon those branches of the intercostal nerves which are freely supplied to the subserous tissue underlying the parietal peritoneum for an explanation. It is not until considerable distension or adhesion has taken place that any reflex cardiac or respiratory effects are observed in operation, nor is any expression of pain elicited when operation is done under local anæsthesia, unless distension or adhesion is present.<sup>1</sup> If man's consciousness of his contents is the cause of his discontent, it is probably to the loose arrangement of the tela subserosa as it passes from the parietal to the visceral layer that we owe that forgetfulness of our viscera which constitutes a large part of our somatic comfort. The same anatomical arrangement explains those not uncommon cases of gastric ulcer which present no pain, cause no complaint, and remain undiagnosed until either hæmorrhage or perforation calls attention to them.

There is a symptom associated with gastric ulcer (especially, though not exclusively, in its chronic form) of which I have found no adequate mention in the literature of the subject. Intercostal neuralgia, especially on the left side, accompanied often by tenderness over those vertebræ which correspond to the nerves involved, is, in my experience, quite common. I have seen several cases in which the primary cause of complaint was intercostal pain, often attributed to the heart, and there was often tenderness near the mammæ where the nerve pierces the muscular fascia to become superficial. Gastric tenderness on pressure, the incidence of pain soon after food, and possibly a history of unsuspected melæna, in a chlorotic patient are sufficient to put one on his guard. It was not until I learnt of the nerve supply of tactile sensation in this neighbourhood that I could find a satisfactory explanation for the pain. As Mr. Mansell Moullin has pointed out,<sup>2</sup> "inflammation, starting from the lymphatics that drain the region of the ulcer, spreads to the parietal peritoneum and makes it infinitely more sensitive.

<sup>1</sup> *Lancet*, March 4, 1905, p. 565.

<sup>2</sup> *Ibid.* in loc. cit.

. . . . The lymphatics, which drain the greater part of its wall, converge towards the pylorus and the lesser curvature. Whenever there is an inflamed area on the mucous surface, or a sore which is irritated by contact with the acid gastric juice, these lymphatics and the parietal peritoneum in connection with them become inflamed. The inflammation may not be severe, though, from the frequency with which thickening of the peritoneum, adhesions, and enlarged glands are found in operations upon this region, it is certainly more general than is usually imagined; but it is quite sufficient to make the least pull upon them more sensitive than it was before." He passes on to explain the greater pain of pyloric ulcers by the greater freedom of the muscular contractions in that part of the stomach. It is easy to understand how continued irritation of the nerve endings of the intercostal nerves in the parietal subserous tissue should, sooner or later, set up reflex pain along the chief intercostal nerves themselves; and the relation of intercostal pain to gastric ulcer is plain enough.

It has seemed to me that it might be not unprofitable to trace out how far these facts can be found represented in the pathogenetic effects of some drugs known to be useful in ulcer of the stomach. I have noted the occurrence of dental troubles and of constipation in the provings as I came to them, though it is obviously not rational to expect that pathogenesis will correspond to the remote causes as well as to the integral symptoms of effects of those causes. The association, where it occurs, is interesting; but its absence, where it does not occur, is not destructive of any degree of pathological similarity which may obtain in the drug effects and the symptoms of the definite disease as it presents itself for treatment at our hands.

The following symptoms of *kali bichromicum* appear to me to illustrate the association of symptoms of gastric ulcer with reflex intercostal pain, constipation, and alveolar abscess :—

*Post mortem*.—Animals, chiefly dogs and rabbits, thirty-nine in number. In almost all cases the stomach was specially acted upon. There were red spots here and there,



or it was slightly inflamed, and had at the bottom several patches of blood extravasated between its coats, with similar patches in the duodenum. In sixteen, at the cardiac orifice and central portions of the stomach were extensive superficial ulcerations. Over the rest of the stomach were scattered deep, irregular ulcers of a greenish colour, penetrating completely through the mucous membrane.

*Symptoms.*—Great uneasiness in stomach and soreness and tenderness in the region of the same, particularly in a small spot to the left of the xyphoid cartilage (88).

Disposition to constipation, and when that exists the general symptoms are aggravated (106).

The pain in the stomach is confined to a spot the size of a thimble, about a hand's breadth above the navel (109).

His general appearance is anæmic. The bowels are always costive, requiring cathartics frequently, which produce temporary relief (158).<sup>1</sup>

Extreme nausea, with inability to vomit, constipation during proving ("Encyclo. D.P.," vol. ii., p. 167).

Deep-seated, dull, shooting pains under scapulæ (*ibid.*, p. 168).

Pain to left of the xyphoid cartilage, nausea; while walking, five irregular stitches in left breast without palpitation and unconnected with respiration (*ibid.*, p. 168).

Vomiting of undigested food on moving about—food quite undigested and not in the least acid, transient darting in mammæ (*ibid.*, p. 169).

Transient stitch at inferior angle of left scapula (*ibid.*, p. 169).

Nausea. Slight circumscribed pressive pain in left hypochondrium. . . . During night awoke with heartburn and had slight transient pain in middle of lung (*ibid.*, p. 170).

Sharp shooting in left chest, pain round navel having gradually disappeared (*ibid.*, p. 171).

Transient acute pain at base of left scapula (*ibid.*, p. 172).

Retching and vomiting throughout proving. An oblong, very painful abscess formed between upper lip and the gum above the eye-tooth (*ibid.*, p. 177).

<sup>1</sup> The numbers above refer to symptoms in "Materia Medica, Physiological and Applied."



Sickness. Transient, sometimes severe, stitches beneath one of the pectoralis major muscles, and at another time in one of the intercostal muscles (*ibid.*, p. 178).

In vomited mucus there are clots of bright blood of size of hazel-nut. . . . Pit of stomach sensitive to touch, and slightest touch causes tendency to vomit (*ibid.*, p. 190).

Pretty strong stitches in region of left nipple in forenoon, after a few hours only when taking breath (*ibid.*, p. 199).

These symptoms illustrate the tendency by which kali bichromicum symptoms are aggravated by the presence of constipation. The occurrence of an alveolar abscess, though single, is suggestive, and the incidence of reflex intercostal pains in association with symptoms pointing to a pre-ulcerous condition is well marked.

The somewhat scanty provings of uranium, though they point very definitely to its influence in determining ulceration of the stomach, especially towards its pyloric end, give us only one symptom which can be claimed as due to intercostal pain, "radiating pain from left side of ensiform cartilage, coming and going for at least two days, aggravated by fasting" ("Encyclo. of D.P.," vol. iv., p. 375).

Argentum metallicum and its salts, especially the albuminates of silver, have an interesting relation to gastric ulcer, for they appear to exhibit a close pathological correspondence with the process right up to the formation of ulcer, and, indeed, to correspond with the ulceration itself if we include the effects of poisonous doses of the solid nitrate in the stomach. To include this, the gross effect of direct chemical action upon tissue, as a pathogenetic result, would, at first sight, appear irrational. But you will, no doubt, remember the ingenious experiment of Dr. Clarke in a proving of argentum nitricum ("Encyclo. of D.P.," vol. i., p. 372), by which he established that long, white patches on the posterior palatine pillars were the result of the absorbed salt and not of the local action of the solution as it passed the pillars in the act of swallowing. The close similarity of the strictly pathogenetic developments and the local action in this proving, taken together with the similarity of the phenomena of local application and systemic intoxication in

the conjunctiva, to which I have called attention elsewhere (*Monthly Homœopathic Review*, January, 1905), give us special warrant for attaching importance to the local action of nitrate of silver.

We find, then, that "silver produces a decidedly anti-plastic effect on the blood, making that fluid more fluid, darker, and more prone to the formation of ecchymosis and effusions" (a condition favourable to separation of the gastric mucous membrane from its blood supply). "A longer continuance of this influence produces chlorosis. The blood corpuscles give up their hæmoglobin to the plasma, become transparent and pale, and are altered in shape" ("Encyclo. of D.P.," vol. i., p. 348). It is found that these changes, together with loss of weight and obvious malnutrition, occur equally whether a peptonate, albuminate, or the nitrate of silver are used (*ibid.*, p. 349).

Together with nausea, faintness, and vomiting after a sensation as though the food lay in a lump in the stomach, stinging, ulcerative pain on the left side of the stomach, directly below the false ribs, more intense during deep inspiration and when touching the parts, we meet with constipation (as an occasional variety to the more usual diarrhoea), and such symptoms as these in the external chest. "Cramp-like pain in the left side of the chest: after the pain has subsided the place is still tender to touch"; cutting, as with a fine knife, across the cartilages of the false ribs on the left side (the spot pains on pressure, as if bruised); slowly intermittent, dull stitches under the cartilages of the last true ribs on the left side. I do not find anything particularly suggestive in the oral and dental symptoms.

It is unnecessary to go exhaustively through the vast pathogenesis of arsenicum. Its relation to chlorosis, to dyspepsia, to acute gastritis, to malnutrition, are obvious enough, and its place in the treatment of ulcer of the stomach is well established. I cannot satisfy myself that any of the intercostal symptoms are directly related to irritation of gastric origin. It is otherwise, I think, with the intercostal pains of arsenicum iodide. The importance

of the gastric symptoms of this drug has been somewhat overshadowed by its reputation in respiratory troubles. It is, moreover, worthy of notice that a dog experimented upon by Thomson ("Encyclo. of D.P.," vol. i., p. 465), into the chest of which ʒss. of a solution (strength not mentioned) was injected, died in fifteen minutes, and the stomach was found much inflamed and thickened, the duodenum slightly so. The inference is that iodide of arsenic absorbed into the blood-stream is excreted, like iodide of potassium, through the peptic glands.

Cadmium sulphuratum is a drug deserving attention in this connection. It presents nausea, retching, and vomiting, sometimes of black fluid. It has also some symptoms suggestive of intercostal pain. It has been found ("Encyclo. of D.P.," vol. i., p. 661), that soluble salts of cadmium "injected into the cellular tissues or the blood-vessels excite an inflammatory irritation of the mucous membranes of the stomach and intestines, and frequently even hæmorrhage, erosion, and ulceration." It is worth remembering that cadmium symptoms are relieved by eating, a modality sometimes, though rarely, met with in gastric ulcer.

Atropin sulphate has been extolled for the relief of pain in gastric ulcer. There is nothing in its provings to suggest that its action herein is based upon the law of similars.

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Dr. SPEIRS ALEXANDER said that a good many of the considerations which Mr. Wilkinson had brought before them were of a pathological nature, and while these would aid them in the selection of the remedy, he thought they would still find their chief resource from a consideration of symptomatology. If they could keep the symptomatology of the drugs clearly before them, they would meet with a great deal more success in daily practice than by trusting to purely pathological circumstances. Oral sepsis was a valuable point in the causation, not only of gastric ulcer, but of all gastric conditions. One found it frequently in chlorosis, and again and again he had found it necessary to have the mouth put into an aseptic condition before it had been possible to do anything for the chlorosis. That, along with colonic constipation, was a point of the utmost value. Mr. Wilkinson had called attention to another point which was of great value; that was

that they should not wait until hæmorrhage had taken place before deciding that the patient had got gastric ulcer, or was going to have it. In the latter condition, as well as in many other diseases, there was a stage which preceded the actual formation of the ulcer, and in that stage a good deal might be done in the way of prevention. He thought that arsenicum was a drug which should receive consideration in such circumstances. He remembered a case in which all the symptoms pointed to gastric ulcer, but, as there had been no hæmorrhage, it was impossible to say that an ulcer was actually present. The symptoms indicated arsenic, which was accordingly given, in the third decimal dilution, over a period of several weeks, after which the patient made a good recovery.

Mr. DUDLEY WRIGHT said that he was particularly interested in the opening part of the paper with regard to the excretive and eliminative action of the mucous membrane, because some time ago he read a paper on that very subject in its relation to chronic catarrh. His views were not altogether favourably accepted by those who heard them at the time, and he was therefore very glad that Mr. Wilkinson had very forcibly advocated the same opinions with regard to the mucous membrane of the stomach. In his own paper he had put forward the view that every portion of the mucous membrane had an excretive as well as a secretive action, and that there was a certain amount of selective action too—that is to say, the mucous membrane of the nose and throat would excrete certain toxins, which probably the mucous membrane of the stomach and duodenum would not do; and that the intestinal track on the one hand would excrete in the same way, and would probably take hold of other toxins. The paper combined, in a very fair way, both the pathological and the symptomatic indications of remedies. In intercostal neuralgia there were pains along the spine, in the scapulæ, and so on, which were particularly indicative of various remedies, and they had very often a great deal of difficulty to account for the reason of these pains appearing. To a certain extent they would have the explanation if they looked to the deeper-seated origin of these pains. He would like to mention two particular spots, tenderness on pressure on which was nearly always associated with gastric troubles. One was just above the insertion of the ensiform process into the body of the sternum, and the other a spot just over the angle of the scapula on the left side, where the triangular portion is uncovered by muscles. It had been proved that atropin in fairly big doses, as given by the allopaths, not only dried up the mucous

membrane of the throat and nose and stopped the secretion there, but also stopped to a great extent the secretion of hydrochloric acid. Personally he was liable to suffer from hyperchloridia, and had to be extremely cautious in his diet on that account. Atropin to a certain extent relieved, but hypodermic tablets of atropin  $\frac{1}{800}$  grain combined with morphia in quarter-grain doses immediately stopped it in his case, and were very suitable in giving that temporary relief which was often necessary owing to the burning pain which was brought on by any dietary indiscretion. In the case of an extremely bad cold of the running type, he had found that taking one of these hypodermic tablets usually quickly stopped it, at the same time it enabled him to eat almost any food he cared to take without producing hyperchloridia, when, in ordinary circumstances, that food would produce acidity.

Dr. WATKINS said that recently, owing to the now frequent opportunity of inspecting the stomach in cases of gastric ulcer, a very interesting discovery had been made. Cases had been diagnosed as gastric ulcer, and on the operating table no ulcer had been found, but patches of the mucous membrane presented a raw granular surface, and were bleeding freely from many points. Other cases had been found where there was a simple linear or stellate fissure with swollen edges, and between the edges there was a continual flow of blood. It appeared that this condition was the precursor of a gastric ulcer, but it was only to be seen in a living person, and could not be seen *post mortem*, because gastric digestion soon removed all trace of it. That seemed to be the explanation of many of the cases where, during life, a gastric ulcer had been diagnosed and *post mortem* no ulcer had been found. It had been proposed to call this condition erosive gastric ulceration. It was very readily treated surgically by passing a purse-string suture round the diseased area. He would like to know how it was that symptoms of gastric ulcer were relieved by gastro-enterostomy.

Dr. LESTOCK REID said that he roughly divided the cases of gastric ulcer into two classes—those which could be cured by putting to bed, and those who could not be put to bed. The vast majority of the first could be cured by kali bichromicum. In about a week or two he generally put them on protoxalate of iron as well. A great many got on quickly and kept well for a good length of time. If the pain was severe, good could be done for the first few days by whitewashing the ulcer with carbonate of bismuth. He gave a spoonful about twice a day. It would stop the pains pretty well. The action was purely mechanical.

As regards associated conditions, such as oral sepsis, the mouths of the patients were often bad, but, in his opinion, that had not very much connection with gastric ulcer. If the patients were sent to the dentist and their mouths were set right, it would be found that that did not cure the stomach. He thought there was much more connection with the state of the colon. Very often there was a certain amount of catarrh, and they would often find mucus in the stools.

Dr. WYNNE THOMAS said that when he had the honour of reading a paper on gastric ulcer before the Society, in 1891, he made a point in reference to tight-lacing. He had quoted a number of cases in which *post-mortem* examinations had been made, in which there had been found a definite line on the liver from tight-lacing, which was continued across the stomach, and it was in this line across the stomach that the ulcers most commonly occurred. When he read the paper, the question of tight-lacing was pooh-poohed all round, and everybody smiled. The great difficulty in these cases of gastric ulcer was to separate the cases of true ulcer from simple gastralgia. In some cases he thought it was impossible to do so. Where they had hæmatemesis there was little doubt that an ulcer was present; but in nine cases out of ten they did not get hæmatemesis. He had met with at least three cases *post mortem* that had died from perforation of the stomach, in which there had been no hæmatemesis whatever. Two of the cases had not been under treatment at all; they had slight indigestion, but thought nothing of it, and so they had not been seen by a doctor until the friends had called one in because the patient was dying. There were two points which he thought could be relied upon in deciding whether the case was gastric ulcer or simple gastralgia. One of the points was the pressure point, that is to say, the tender spot, which was usually to be found between the eighth and ninth dorsal vertebræ. The second point was the fact that galvanism would in cases of true ulcer have very little effect on the pain, but in cases of pure gastralgia in a few minutes galvanism would relieve the pain entirely. Gastric ulcer seemed most commonly to occur in cases of anæmic girls, and very little had been said about treating them with iron. He thought most of these patients required iron either as carbonate or as protoxalate, or in some other form. They had heard of bismuth being used to whitewash the stomach; it certainly relieved the pain, and he believed that it was pathologically indicated as well. Hæmatemesis in these cases did not as a rule kill. One reason, perhaps, was that when a patient brought up a large

quantity of blood she was at once put to bed and taken great care of and fed very carefully. Dr. Macnish had stated that it was still a mystery why the gastric juice did not injure the walls of the stomach itself. Mr. Wynne Thomas drew attention to the fact, that while the process of digestion was in progress that the walls of the stomach were engorged with blood which was alkaline in reaction, and therefore neutralised the acid from acting on the lining membrane, also that the acid contents were constantly being moved about while digestion was going on.

Mr. WILKINSON thanked the speakers for their kind reception of his paper. It could not be too plainly understood, he thought, that the attitude of the homœopath towards pathology was not one of enmity. Pathological considerations and symptomatology were twin brothers; but the former was very badly nourished. Their knowledge that derivatives of morphia were excreted by the mucous membrane of the stomach might give them some little reason for prescribing morphia in stomach conditions. Of course, he regarded tight-lacing as being a very important factor, indeed, as a contributory cause of ulceration of the stomach; but it did not come within his purview that evening.

## WHOOPING-COUGH A STILL UNTAKEN CITADEL.<sup>1</sup>

BY ELEAZER BIRCH ROCHE, L.R.C.P.LOND., M.R.C.S.ENG.

*Physician to the Norwich Homœopathic Dispensary and Orphans' Home.*

MR. PRESIDENT AND GENTLEMEN,—My first word must be one of apology, that, owing to circumstances quite unavoidable, I have been unable to adequately carry out my ideal in preparing this paper and presenting to this Society a communication which I feel is in some reasonable measure worthy of the occasion. The more so that I am unable to be present as I had hoped, and am obliged to trust to the kind offices of the Secretary to read it for me.

There was a time when the immeasurable superiority of homœopathic treatment, with the extraordinary weakness

<sup>1</sup> Presented to the Section of Materia Medica and Therapeutics, May 4, 1905.



and deficiency of ordinary practice, gave to our school an advantage which was on all hands practically demonstrable. Surgery was, for the most part, outside our general practice, and the multiplicity of treatment by its means in so many directions practised to-day was altogether unknown. Specialism had not exercised that transforming influence on medical practice which is now so widely felt. As general practitioners in all the wide range of cases treated by medicine only, homœopaths could more than hold their own with ease, and were constantly impressing the onlooking public with the great success and evident advantage of their treatment.

As years have gone by the developments of surgery, with its widening domain, its undeniable claims, prompt successes, and fashionable influences, have placed the country homœopathic practitioner at rapidly increasing disadvantage. In large centres where the help of colleagues is available, and facilities at hand, opportunity has presented, and has been seized, of adopting all modern surgical measures as and when they have tended to invade what was once medical territory, and their adoption proved advantageous to the patient.

The advances of specialism, too, with the positive results of local treatment of various kinds, and dexterity in manipulation and use of instruments of diagnosis, and treatment, have given to the dominant party an advantage that a few decades since was not theirs. And as regards medicine proper, though there has been very slow advance notwithstanding much plagiarism, the introduction of serum therapy and the discovery and use of the long list of synthetical products, albeit many of them but palliatives at best, and having but temporary vogue; yet these have touched strongly the public mind, and such results as can be obtained by the varied use of cocaine, eucaine, urotropine, metramine, thyroid, and other animal extracts; renaglandin, and others; trional, veronal, antipyrin, phenacetin, and troops of others, have raised the medical status of the old school from a position of helplessness and uncertainty, off which the most ordinary practitioner of homœopathy in early days could constantly score, and even amateurs had no difficulty in demonstrating the superiority of the law of similars. In my experience,



and in spite of strenuous efforts at adaptation, the position has very seriously changed, and for the country and isolated practitioner has become very difficult, and, with a conscientious consideration of the interests of the patient, has led to the frequent and, owing to the trades unionism in exercise, complete handing over of patients into unfriendly hands, when all the advantages of the situation are used to impress and alienate them, and this especially and successfully with the younger ones.

I am by no means desiring to take any unduly dark view of the outlook, but, with the constantly increasing effects of all these things on the public mind, and especially on the younger ones, with impatience for immediate or rapid effects, the glamour of brilliant surgical results, and the growing importance of those who can carry them through, cannot be ignored. The influence exercised by these surgeons and specialists on the minds of our patients, in most cases to the exclusion and disparagement of the homœopathic practitioner, has narrowed the sphere, lessened the influence, and diminished the former exhibition on all sides of those striking and constant triumphs of his treatment where others had failed. Personally, I have less to complain of than many, but this line of things, with its trying experiences, has led one to value those planes, still not a few, where our homœopathic medication can not only vindicate a superiority, but especially those where that superiority is not only capable of being seen, but must force itself on the attention of all observers. Such an opportunity is afforded by the treatment of whooping-cough.

Here surgery has no chance, and specialism has only begun to make claims that have yet to be proved. Whooping-cough is a common disease, unmistakable, forcing itself on the observation, experience, and endurance of nearly every family. All kinds of nostrums and fashions have had their trial upon it, and yet to-day it remains one of the common complaints for which ordinary practice has no certain remedy. This is, then, a disease that affords to any twelve ordinary persons the opportunity of trying the question, and most surely giving a verdict in favour of homœopathy, over any given series of cases, taken as they come.

Differences of opinion obtain in the profession as to the exact character of the disease, and I am sure it would be very much out of place for me to take up your time reviewing the various theories and contentions as to its pathology. We may accept the general statement that it is a spasmodic bronchial irritation of contagious and usually epidemic character, generally affecting children, seldom occurring a second time, and in its *ordinary* course extending to eight weeks, and in many cases lasting three months and even longer. Frequently attended by complications, pulmonary, trophic, or convulsive, and when combined with dentition these complications are more likely to occur. The mortality is by no means insignificant, the loss of time, strength, and family comfort is great, and the sequelæ are by no means a small consideration. This, then, being the disease, and, owing to its character and prevalence, well known to the profession and also to the public, it has, as might have been expected, been treated by measures and drugs innumerable, and exhibiting all the various fashions so amusing to one taking note of their rise and fall. Cochineal, bromides, chloral, cypress oil, antipyrin, phenacetin, bromoform, chlorobrom, morphine, carbon dioxide, thymus serpyllum, oil of amber, cresolin and other vapours, gas purifiers, sulphurous and nitric acids, naphthalin, euquinine, alum, resorcin, and hosts of others have had their champions and their day, but none have established themselves in any general favour. Nothing is known on this long list that unmistakably and constantly controls and within the usual limits of its natural duration brings it to an end. Brown-Sequard declared that he could cure it in three days by giving atropia in doses large enough to produce delirium and continued so as to keep up that condition for three days, except at night, when the patient is to be quieted by morphia or codeia. He, however, candidly added that it would be hard to get the consent of the parents to this mode of treatment, and he does not tell us in how many cases he did apply it. Manicatide states that he has discovered a bacillus in this disease, absent, he says, in only five out of eighty-two cases. He made cultures and immunised three sheep and two horses. Blood from

the jugular vein was the source of the serum. In a sheep the injection of cultures at first caused symptoms resembling whooping-cough. The serum was preserved by adding to every 10 cc. 1 cc. of a 5 per cent. solution of carbolic acid. He states that he treated eighty-one cases of whooping-cough with serum only. Of these thirty-six were cured and the remainder only improved. The cures were obtained in one case in one day, in two cases in two days, in one case in three days, in three cases in four days, in three cases in five days, one case in six days, three cases in seven days, three cases in eight days, two cases in nine days, six cases in ten days, and so on. Eight cases were cured with a single injection, eighteen cases required two injections, and the others from three to six. This is a *recent statement* on which I am not in a position to comment. If reliable, then once more the syringe is in the ascendant. Nothing, then, in ordinary practice has established any reliable reputation, and whooping-cough medically treated is an acknowledged opprobrium. A medical practitioner recently said, "I have been using cresolin, but I have no proof that it does any good; nothing seems to do any good. I use antipyrin amongst my dispensary cases." But I did not gather that he had tried this heroic treatment at home.

Fifteen years ago I was requested by a lady of property to go over to her village, which was, as to its children, practically all whooping-cough. Three families were under her jurisdiction, and she took me to them one after the other. Each family consisted of five or six children, and I examined them all. They had whooping-cough, but without complications. I gave them ipecacuanha and drosera to be taken alternately every two hours, and belladonna for use at night for those whose cough was specially troublesome then. I ordered for the lady good supplies of these remedies in pilules, 1x, with general directions, and saw them no more. The upshot was that in that village the three families so treated made steady progress and recovery in about four weeks, while the other children pursued the usual course for five or six weeks longer. Since then I have treated a large number of cases with the same medicines. I have not lost a case, nor have I had

complications, except in a few very young patients who were teething. The usual course has been a cure within four weeks from the date of commencing this treatment.

But an important point which appeals to those concerned is that improvement in the symptoms begins almost immediately, paroxysms lessened in frequency and force, sickness diminished or almost abolished, the condition of the child correspondingly improved, and, above all, the nights of the patients, and still more of the nurses or parents, markedly bettered, which is a matter of the greatest importance where poor people especially are concerned, with close quarters and daily labour, and this still more where several children are affected at the same time. I have before me the reports of a large number of cases recently treated. All did well, though some were very ill before they came to hand. In the large majority of cases the treatment made its mark within twenty-four hours, and in case after case turned in a few days a distressing condition into a palpably and steadily improving one. Where cases were early under treatment, as in my own children, the whoop never developed, though there could be no mistake as to the disease. The general condition was not impaired, nor feeding interfered with, nor any frequent sickness set up.

One father writing to me said: "When I remember the long and trying time we had fifteen years ago when my now grown-up son was, under different treatment, laid up for two months with the same complaint, and contrast the terrible spasms and the nights of coughing he had, and then a further long period of convalescence, I am all the better able to appreciate the result." Another family of four children, at a distance, whom I did not see, had been ill for some time, three weeks night and day constantly vomiting and coughing almost every hour. One girl kept her bed for a fortnight, blood spurting from nose and mouth frequently with the violence of the paroxysms. At the end of three weeks the symptoms were slight, the eldest boy well, and the others well on the way for it.

A missionary friend, on furlough in Scotland, whose children I heard had whooping-cough, and who feared a

disturbance of his embarkation to return to Manchuria, was written to by me giving advice. He wrote later on saying: "Our family doctor, a great friend, prescribed chlorobrom for them, and this they took at the start. We, however, afterwards gave drosera and aconite. The effect was wonderful, and the *whoop* disappeared in about ten days at the outside. Ipecacuanha and belladonna were given after this at your suggestion, and all cough speedily disappeared." They were able to take their passage for China, which had appeared at first quite hopeless.

I saw a baby of a year old for cough of two weeks' duration, supposed to be from cold, and gave medicine. At the end of ten days the father came saying the child was worse, that they got no rest at night, and described what was evidently whooping-cough. The mother said she was coughing every few minutes, with constant sickness, and they were quite worn out with disturbed nights. The father and mother were intelligent working people. Treatment was at once commenced. Ipecacuanha and drosera by day, and belladonna at night. In three days the cough was much less, the nights greatly improving, and from that time steady improvement went on, resulting in a cure in four weeks. The interesting point was that this baby contracted the disease from a child 4 years old into whose house it was taken, and who had then had a bad cough for nearly three weeks, but only whooped after the baby had been in contact about the end of the second week in December. Then the cough got worse and worse, whooping constantly with sickness; the nights were very trying, obliging the mother to be up almost every quarter of an hour. This continued until January 24, when, having had the cough seven weeks, the child was as bad as ever. The mother had meanwhile seen the baby infected from her child develop the disease and get cured. She now came begging treatment for her child. The same medicines were given. On the fourth day the child could eat a little and keep it down, the nights began to improve, and at the end of the second week she was eating fairly and sleeping much better. The note on February 17 was: "Has good nights, does not wake up at all. Eating well, only coughs two or three times a day."

Recently, when visiting a patient, I heard a little girl 2 years old coughing and whooping most distressingly. I spoke to the mother and offered help. The child was sick and had very bad nights. I gave the same treatment. In a few days improvement was manifest in all respects, and in about three weeks the child was well. Now for the source of the trouble. The elder brother was in the country staying with his grandmother, and had a cough about Christmas. He came home on January 10 to go to school, but, owing to the affection being evidently whooping-cough, did not go, but returned to his grandmother. The little sister then developed cough, and at the end of three or four weeks came under my notice as above described about February 13. She made immediate and steady progress, and by the 27th did not cough from 10 till 7, and was rapidly getting well. She being well, the boy returned home again still bad with the cough at the end of nine weeks. The mother asked for the same treatment for him. He also began at once to improve, and in three weeks was well.

I might multiply such cases, but these demonstrate the points to be observed in all, and plain to all ordinary observers, with the usual practical knowledge of what is the common course of the disease untreated or treated with the ordinary remedies. It can be seen by all such observers that the advent of homœopathic treatment is quickly and manifestly beneficial, and curative in a time very much shorter than the known usual duration of the disease. It is because the existence of such cases side by side furnish such a convincing and unanswerable proof of the truth and value of our homœopathic treatment, and furnish us with what has become more difficult of late years, a safe ground of appeal and experiment of the comparative value of our methods with anything that can be done by our opponents. This is my excuse for bringing before you such elementary matters. The situation in regard to whooping-cough has been a special help and comfort to me, and I hope may claim your sympathy for those who have to carry on the warfare alone and with many disadvantages and discouragements.

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Dr. JOHNSTONE, in opening the discussion, said they would all agree in what the author said with regard to the insistence of the public on having quick relief. The public were so well acquainted with sulphonal, and cough lozenges containing morphia and bromides, and things of that kind, that when they were in pain, or suffering from something urgent, they always wanted instant relief, and would not wait a few hours for homœopathic remedies to take their full effect; and therefore sedatives were often employed before a recognised homœopathic practitioner was called in.

Dr. ROBERSON DAY said that in hospital and private practice there was no more successful disease to treat than whooping-cough. They were constantly coming across instances of parents bringing children who had been struggling with the cough for weeks, and after a few doses of drosera, which was generally the medicine given, wonderful relief was immediately reported. As regards drosera, he had found that good results were only got by high dilutions, and his dilution was the 30th. The allopaths in their plagiarism had adopted drosera, but the dilution was a bar, and hence they got no results, as they used it in the mother tincture. As regards other remedies, he had found coccus cacti of great service in certain cases which were complicated with gastric pain, flatulence and spasms. The night cough, which was always the worst, he had found yield very well to passiflora incarnata in the mother tincture. That was one of the unproved remedies, but it certainly had a wonderful effect. It was from America, and had been used by homœopaths. When he had a case to treat from the first he scarcely ever saw complications, but in hospital practice, especially in the winter months and inclement seasons, the cases quickly ran into broncho-pneumonia, which was one of the most common and fatal of the complications, especially when there was a tubercular taint. A little time ago he saw a patient in consultation with Dr. Münster, which had been under treatment for some time, vomiting having been one of the great troubles; emaciation was severe, and pyrexia followed. This presented a serious appearance, as though general tuberculosis of the lung was coming on, but fortunately this case ended satisfactorily.

Dr. PURDOM said the last mentioned case, which he had seen with Dr. Day and Dr. Münster, was an extremely interesting one. There were all the appearances of acute phthisis; the patient wasted to a skeleton and required night and day nurses; so that the ordinary whooping-cough treatment was out of court, as it were. Iodide of arsenic and other lung medicines were really



the medicines that did good. The patient made a splendid recovery.

Dr. STONHAM said he was surprised the range of medicines adopted by Dr. Roche was so restricted. He himself should not like to be restricted to ipecacuanha, drosera and belladonna, especially as there were one or two others which he had found extremely useful. Perhaps the most useful of these was kali carbonica. In cases with puffiness above the eyes, which was so indicative of kali carbonica, it acted better than drosera or any other medicine. Cuprum was a very good medicine when there were convulsions and the cough was extremely violent so as to cause blood to come up. He had found that drosera was the best when there was a good deal of vomiting, but if there was not much vomiting he preferred to use some other medicine like corallium, or if kali carbonica was indicated, that medicine in the 6th or 12th dilution.

Dr. SPEIRS ALEXANDER said that at one time he used to give the medicines which had been mentioned in the lower dilutions, but of later years he had gone higher, and he thought that cases had recovered in a shorter time under drosera 30, belladonna 12, and so on. He had found cuprum 6 of great assistance when there were convulsions and spasm of the glottis. If his memory served him rightly, the statistics of the Registrar-General showed that more children died from whooping-cough and measles than from any other diseases to which children were subject. It had fallen to his lot to treat many such cases, and to deal with the usual complications, whether pulmonary or spasmodic, and yet he had never lost a case of either whooping-cough or measles. He thought that such an experience bore ample testimony to the advantage of homœopathic treatment.

Dr. MADDEN said he had tried drosera in all dilutions, except as a pure tincture, which he took for granted would aggravate, and he confessed that he had not seen any marked superiority from using the higher dilutions over using 1x. It would be very interesting if they could devise some means of obtaining statistics showing whether there is a definite superiority of the higher dilutions over the lower. He was rather sorry that Dr. Roche had given ipecacuanha as a routine practice in alternation with drosera. He thought that if he had made it his routine to give drosera alone in uncomplicated cases, and belladonna with troublesome night cough, he would have been equally successful.

Dr. WATKINS said that some years ago a writer in the *Lancet*,<sup>1</sup>

<sup>1</sup> December 3, 1898.



said that in every case of whooping-cough he had seen he had examined the ear and he was always able to demonstrate that there was some disease of the ear; that he was in the habit of treating the ears, and that he had met with uniformly successful results.

Dr. H. NANKIVELL said he was pretty sure they would find an anæsthetic applied to the ear often successful in quieting a spasmodic cough, from the fact that ear irritation often produced a spasmodic cough. He had had a very slight attack of whooping-cough which he had caught from two adult patients who were simultaneously suffering therefrom two years ago. He was ashamed to say he took nothing at all for it, for the attack was a slight, though a prolonged one. Change of air had apparently no effect on it, as it continued about the same while passing through Germany and Switzerland and only ceased on his return to Bournemouth.

Dr. WYNNE THOMAS said that in Bromley, among the poor classes, when there was an epidemic of whooping-cough, it was the custom to take the children down to the gas-works once a week when the retorts were opened, and one might see a crowd of between forty and fifty children brought there to inhale the fumes, and they seemed to gain very great benefit from it. Apparently, therefore, English tar was not so far behind Stockholm tar.

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## SLUM PRACTICE.<sup>1</sup>

BY A. E. HAWKES, M.D.

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MR. CHAIRMAN AND GENTLEMEN,—It has taken me some little time to fix upon a title for the paper I have the honour of presenting this evening, but I think I have chosen one which at the present day can only attach—as regards our dispensary visiting—to that part of the city of Liverpool to which circumstances led me for a couple of months last autumn.

I need not remind some of you how I came to be conducting a moiety of the work at the Roscommon Street

<sup>1</sup> A paper read before the Liverpool Branch of the British Homœopathic Society, May 11, 1905.

Dispensary, but I wish to guard myself against even suggesting that workers in other areas controlled by our organisation know exactly what such work really means.

I have done a good deal of visiting in earlier days in the streets between Mill Street and the River Mersey. I remember one of the best cases of enteric fever I saw at that time, 1872-74, was in Wolfe Street. At another period my district included Harding and other streets, since greatly altered by wholesale rebuilding, in the neighbourhood of St. Nathanael's Church.

At yet another period my work extended to Balm Street, Kensington, and even as far as Vipond Street, Whitefield Lane, where I attended a case of small-pox in the good old days. I am willing to whisper into the ear of any of our visiting medical officers how these districts came to be curtailed, but if they take my advice they will not be too inquisitive concerning these matters.

Improvements in the vicinity of Lime Street Station have swept away much insanitary property, but in the days I speak of, I attended several members of a family ill with enteric fever at the same time, all of whom recovered.

On one occasion five cases of scarlet fever had to be attended in one room, if my memory serves me, at any rate in one small court house. One died, I regret to say, but it was in the days of a more virulent type than I have seen of late, the days of the employment of *crotalus* and such heroics; also I may be allowed to say these cases occurred at a time when *ailanthus* was not much in evidence, although *arum* and *rhus* were available. I am not dealing with scarlet fever in this paper, for at the present day we send the cases to the fever hospital, pocket the shilling allowed by a generous corporation, and attend on midwifery cases with a *mens conscia recti* not previously recognised as an asset. Were I discussing scarlet fever I think I could show a mortality of less than 1 per cent. for many years, the solitary death having occurred some little time after the case had been transferred to one of the visiting men of that day. If the type has changed, so have our remedies, *ailanthus* superseding *rhus* and *belladonna*,

and merc. cyan. taking the place of merc. biniod. ; crotalus, lachesis, apis and arsen., with terebinth. and canth. being held in reserve. I mention these geographical and other details in order to emphasise the statement which I make deliberately, viz., that I never saw such poverty as I witnessed last autumn, and that I was never called upon to work in such an unpromising field. I treated one case of tubercle in the neighbourhood. Under arsen. iod. and the open window *régime* the patient gained more than a stone in weight, and although much dulness remained the sputum ceased to contain the tubercle bacillus. But there were many factors in my favour, and these must be briefly referred to. Thirty-eight years previously Dr. Proctor had been chosen to carry the benefits of homœopathy into the district, which was at that time afflicted with cholera. With what results let him who does not know read in the twenty-fifth volume of the *British Journal of Homœopathy*. Since that time Drs. Mahoney, Brotshie, Williams, Ellis, Capper and others have worked in the district with such zeal, that the people are fully alive to the benefits of the homœopathic treatment, and have come to look upon our dispensary there as their own peculiar refuge in time of need.

The epidemic of summer diarrhœa was just passing off when I took up the work, and one or two of the transferred cases died, to my great regret.

One child in a miserable court was still at the breast when I first saw it, but the mother was starving, and the saddest words I ever heard uttered were from her lips: "The milk does seem to flow so when I take a drink of water." The proffered help was too late, and the child died of diarrhœa, according to the certificate. May the *suppressio veri* be forgiven.

While I am quoting remarks overheard, I may say that the most unnecessary one I listened to was an appeal to the Deity as to the necessity or otherwise of using soap to wash a doorstep. The most amusing thing I witnessed was a child just able to walk, in the act of bringing its heel down upon the head of a wax vesta. The expected did not happen; an illustration of "the light that failed."

I do not at any length refer to the subject of diarrhoea, as Dr. Capper's Congress paper<sup>1</sup> is still fresh in your recollection, and his results were for the most part obtained in this district. This excellent brochure will surely be a valuable addendum to the works of reference available to our visiting officers.

I must, however, refer to one striking case in which the well-known indication for *æthusa cynapium*, "sudden vomiting of curdled milk," was quickly successful. I was asked by Dr. Drysdale in 1875 to send a short contribution to the *British Journal of Homœopathy* embodying the results of Dr. Harley's experiments with *æthusa*.

These, together with the results of taking *3ii.* of the expressed juice by Dr. T. F. Allen, would almost warrant the exclusion of the drug from our medicine chests, and yet there are cases which *æthusa* seems to help better than any other drug, and thus often the refinements of homœopathy, difficult as they may be to master, come to our aid. These refinements could be made much more constantly available if our practitioners would publish their results more often, thus forming a clinical counterpart to the prover's notebook.

I was astonished at the number of *merc. cor.* cases which presented themselves late in the epidemic. I found my colleagues frequently using the remedy with good effect. I do not allude only to those cases which are characterised by muco-sanguineous evacuations with tenesmus, but to cases more like *merc. sol.* and, perhaps, *mag. carb.*

We saw several cases of prolapsus ani. *Pod. 3* was very useful, but I hope I am not disparaging the drug when I remark that one case did not do well, even under the medicine in question, until it was removed to the hospital, and so to careful dieting and the necessary skilful mechanical aid rendered by a trained nurse.

As heretofore I was much pleased with *croton tig. 3* in the well-known watery, gushing cases aggravated by drinking.

<sup>1</sup> Read in London, July 1, 1904.

The question of children's diet in this district demands a word or two. The habit of nursing a child too long frequently comes before the medical attendant, and, as I have already pointed out, one often finds an ill-fed mother thus nursing her child, and it must not be forgotten that many of these cases of diarrhoea occur amongst children still on the breast. For others I found milk and barley water almost universally adopted, except where, with much discrimination, the sterilised milk prepared by the Corporation was used. I do not say that even this is universally successful, but too much cannot be said in favour of this expedient.

The question of the milk supply of our large cities is one of the first importance.

I will not repeat the substance of Dr. Capper's statements with regard to bacteriology, but it may be remarked that out of 1,350 samples of town milk twenty-five were tubercular, not quite 2 per cent., whereas 1,686 country specimens afforded 106 tubercular results, more than 6 per cent. These statements occur on page 191 of Dr. Hope's report for 1903. One year gave 5·6 per cent. for country milk and ·8 per cent. for town milk.

Much the same proportion obtains with regard to the *Bacillus coli*, and the spore-bearing bacillus the *Bacillus enteritidis sporogenes*. The *Bacillus coli communis* occurs in the water of localities where typhoid fever prevails, and in the intestines of suckling infants.

It has been demonstrated that the *B. coli* almost equals in virulence the *B. typhoides*, and that with *B. coli* animals have been rendered immune against *B. typhoides*.<sup>1</sup>

I must not further refer to these matters, but your own microscopical researches in the vicinity of some oft-frequented frog pond, will doubtless call up the old academical fight as to the merits of country and town as carried on in our school-days, and I myself shudder to think of the chlorides, nitrates, nitrites, and albuminoid products which were staple articles of consumption in many villages I knew

<sup>1</sup> "System of Medicine" (Allbutt).

thirty years ago ; some of which to-day resist as long as they can the introduction of a water supply, which, if it does not vie with our own, is at least infinitely superior to their present supply.

As to condensed milk, an elaborate statement will be found in Dr. Hope's report for 1898, page 131.

Taking cream as the chief *desideratum*, I do not say the sole one, the following order may be assigned to the different brands :—

Tip-top brand	...	...	...	11·06
Nestlé's brand	...	...	...	10·88
Milkmaid brand	...	...	...	10·53
Fourpenny brand	...	...	...	9·10
Anglo-Irish brand	...	...	...	9·01

Other milk solids accounted for 25 per cent. Sugar had been added to the extent of 40 per cent.

Many samples, but not these, are made from separated milk. Of the above, one only was pronounced sterile.

The chief questions, then, in the ensuing summer for those charged with this kind of work will be to determine how far the country milk can be sterilised, whether town milk should be exclusively recommended for this purpose, and whether the large amount of sugar rules the better condensed milk out of court, or whether they had better try the milk-powder so greatly lauded last autumn by the *Liverpool Daily Post*.

I have no doubt that the nursing mother is greatly helped by taking oatmeal or cocoa, to either of which as much milk as possible should be added.

Stout is of doubtful value, and we are discussing slum dietaries into which we, at any rate, do not need to introduce alcohol.

Some of us have used cream with advantage mixed with water in varying proportions.

Of eighteen samples of cream examined the spore-bearing bacillus was absent in all cases, but the *Bacillus coli* was present in twelve of the samples.

It is not necessary for me to refer at any length to the employment of sterilised milk prepared by the Liverpool

Corporation. All that can be said will be found in Dr. Hope's report, but it is obvious that if our dispensary as a life-saving instrument is to be used to the greatest advantage, either the State or organised philanthropy should see to it that hand-fed infants are supplied with the least harmful of the many artificial dietetics suitable for infant wants.

It has come to my knowledge that a great milk factor is devoting his energies, with the aid of the best scientific help, to render the country milk supply free from disease germs and in that state to supply it to the public.

It is outside my present thesis to suggest that an article which at the country-side railway station is worth about sixpence a gallon ought to be available for the poor at something less than even threepence a quart. Railway stock has never occupied my attention.

It cannot be long before our farming friends will see to it that their milch cows obtain the purest drinking water available.

From infantile diarrhoea to enteric fever is not a far cry. During these two months I had only to deal with two cases, and one of these I had removed to our hospital, where she did well, but we had one or two relapses to combat. I hold very strongly the view that no effort should be spared to make an early diagnosis, as the danger of a late removal is, in my opinion, very great.

In a former paper<sup>1</sup> I drew attention to my results while treating typhoid fever, and, although we once had a run in the hospital of twenty-nine successful cases, I have never obtained quite such good results in hospital as those referred to. Of course, in hospital we have to deal with cases sent in late.

The other case was a good example of the ambulatory type of the disease. The young girl came to the dispensary two or three times looking very much like a tubercular case. Her lungs were examined, with negative results. The fever continued, and she was again examined, Dr. Edmund Hughes inclining to the belief that the spleen was large. She was

<sup>1</sup> Not published.

thereafter visited at home, and a capillary tube of blood sent to the Thompson-Yates Laboratory gave the positive reaction. The agglutination test is now about ten years old, and its employment removes a source of anxiety from our calling. It is all very well for my friend Dr. Crawford, formerly of Chicago, to say to his students, "I am determined that you shall know a case of typhoid fever when you see it," but it is not always possible to make an early diagnosis.

Having diagnosed typhoid fever, we can hold our own in the treatment of it. I once had five members of a family under treatment in the hospital at one time; all did well. Long ago, in Dr. Drysdale's day, and with his help, I treated seven cases in one small house, the father, mother—who aborted—and five children; all did well. I hope never again to see a case of perforation without some attempt to stitch the rent being made. I next come to diphtheritic cases.

I have seen three cases at the North End. The first, in a boy, may be described as membranous laryngitis. No membrane could be seen on the fauces, and the Klebs-Löffler bacillus was not found in the rather meagre supply of exudate sent.

Bromine, bovril, and stimulants in small quantities all seemed necessary to the cure.

As only the streptococcus was found the case was not reported.

A younger child had a more pronounced attack, and membrane invaded fauces and larynx.

The case was reported, and the patient sent by the authorities to the hospital. I thought it was much better from taking bromine, but the child died soon after its removal.

We were recently sent for very late to a similar case. We did all we could, but the patient died. I took up some serum, but it was too late.

Gentlemen, in view of our present knowledge, it seems desirable to have each case microscopically examined. One cannot determine for another what his attitude towards the serum treatment should be. If, on the one hand, it is affirmed that the serum treatment has been too much



lauded, since many mild cases have been included, on the other hand, it can be said that the bacillus has been discovered in many mild cases.

The practitioner will study the cases published by our London colleagues in the *Hospital Reports*, vol. vi. He cannot but be greatly influenced by the results referred to by Osler,<sup>1</sup> as having been obtained in the Boston City Hospital. The diminution in the number of deaths is striking. In Chicago the deaths have been reduced nearly one-half. In the district we are to-night concerned with, removal seems imperative, and until we have a ward available in the Hahnemann Hospital for such cases it is perhaps idle to discuss the matter further.

Slum practice hardly lends itself to serum therapy.

Dr. Richard Hughes<sup>2</sup> held strong views concerning the serum treatment. In private practice we may still be called upon more or less often to settle these knotty points.

The next disease I desire briefly to refer to is the broncho-pneumonia of early life. In the autumn a good number of these cases occurred. I saw four in September, and more than twenty in October. Two of these died, one a very puny 7 months child, and the other a child I only saw the day before it died. I attribute the good results to aconite 3 or so, and to the persistent use of phos. 2 or 3. I have long deprecated the use of phos. in the pilule form, but since ordering the pilules in bottles I have been more than pleased with it. We now insist that the drug shall be so dispensed, and with the happiest effect.

Iodine 3x is often required, and in those cases where the temperature runs up to 103° F. or so, falling two or three degrees in the morning, the medicine is very helpful. Long ago I reported a mortality in these cases of about 1·4 in this class of practice. Then I used ant. tart. more, and phosph. less. I shall be glad to hear what colleagues have to say herein.

I have reserved to the last the most serious disease we have to combat at the North End.

<sup>1</sup> "Practice of Medicine," p. 157.

<sup>2</sup> "Principles and Practice," p. 274.

Like typhoid fever, measles is fatal to a different degree at different ages. The mortality at a children's hospital in Paris in the cases treated from the age of—

6 months was 23·68 per cent.			
6-12	„	„	57·77 „
1-2 years	„	„	53·94 „
2-3	„	„	27·73 „
3-4	„	„	13·06 „
4-5	„	„	6·20 „
5-10	„	„	2·4 „
10-21	„	„	0·0 „

At Heidelberg<sup>1</sup> —

Up to 1 year	...	...	14 per cent.
1-4 years	...	...	7·5 „
4-13 „	...	...	2·2 „

It is known that mortality is lessened by separating children suffering from broncho-pneumonia from those not so suffering during any given epidemic. We have not analysed the ages, but it may be stated that of nineteen cases seen during September and October two died. One was seen for the first time four hours before it died in a miserable cellar, of dusky measles, chest troubles, and collapse due to diarrhoea.

The other case died some days after the first visit, but all chance of success vanished in the interval between its abandonment by a local doctor and our visit. I am told that men devoting themselves to private work in such localities cannot go on with cases unless the fee is forthcoming, and must abruptly cease attending.

All honour to him who, for a fee within the capabilities of the patient, does all he can for the case, but this want of continuity is fatal, and I, for one, commend those who can see their way to open consulting-rooms for the poor in the neighbourhood of their official appointments. A house surgeon at the North End would be a boon, but a few months

<sup>1</sup> "System of Medicine" (Allbutt), vol. ii., fol. 100.

would be all he could hope to stay there, regard being had to his own health.

Parents are afraid often to send to the doctor in cases of measles. We have just lost a case under such circumstances. The mother does not know that the disease is not notifiable, and she shrinks from parting with her child. Perhaps the statistics I have referred to discourage removal to hospitals, where the mortality might be much more than the 10 per cent. I record.

I have in the slums used hydropathic measures to get the rash out with good results; but a blanket is often not to be had, at any rate, not without a journey to an establishment where the odds are said to be 2 to 1.

I was much astonished once when a respectable woman said to me that she must run out a minute before sending for medicine to the dispensary. It is due to these establishments to speak well of their legitimate dealings, and of their value to the poor. I found that again and again the necessary coppers had to be obtained from the pawnshop.

I show a little child, who is a native of Opie Street. She came in here<sup>1</sup> wasted to a skeleton, diagnosed as having tabes. Bit by bit of furniture had to go to get milk and pay the rent, but arsen., iod., and phosph. have helped, and it is hoped that work, good weather, and—dare I say?—good luck may gradually restore the lares and penates.

Some charitable institution might afford us some blankets for bad cases, to be properly disinfected and returned to the dépôt. No one can work in this particular district without a current milk account, unless he is hard as adamant; moreover, a few shillings thus spent save many lives.

To conclude, I paid 800 visits in the sixty days—for some Sunday visiting is inevitable—thirteen or fourteen visits a day on an average. I saw 162 cases, averaging four or five visits to each patient. I lost ten cases—a mortality of 6·2 per cent., a little higher than our hospital mortality.

The fatal cases were:—

September.—Epidemic diarrhoea, two; chronic diarrhoea, one; infantile syphilis, one; heart disease, one. Total, five.

<sup>1</sup> Hahnemann Hospital.

All these were from other medical men, and all were hopeless at my first interview.

October.—Pernicious anæmia, an old hospital case, attended for two days; premature birth and bronchitis; morbilli and diarrhoea, attended four hours; broncho-pneumonia, seen once; broncho-pneumonia and measles from allopathic hands. Total, five.

I lost one case to the allopaths. What my friend gave I do not know; his identity must not be disclosed. He is supposed to know homœopathy about as well as, perhaps better than, I know gynæcology. I am thankful to say that the child recovered.

I have thus spent many hours in this locality bounded by Netherfield Road, Prince Edwin Street, Great Homer Street, and Luther Street. In good weather the whole populace is out of doors; at other times the overcrowding must be appalling. This open-air factor, in streets swept by westerly gales, accounts for the comparative health of the people to some extent at least.

I spent the evening of November 5 in the locality. It was a modified pandemonium; doors and other inflammable products of civilisation helping to feed the numerous fires. At times, on Sundays, this interesting part of our territory reveals many a quiet, clean hearth, and a spread of appetising viands, but for the most part lack of labour, poverty, sickness, and death are in evidence, and these fearful visitants call for and obtain the ceaseless attention of the committee of the charity and of our colleagues whom they employ.

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## DEVIATIONS OF THE SEPTUM NARIUM, THEIR CAUSES, COMPLICATIONS AND CURE.<sup>1</sup>

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As the nomenclature implies, deviation or deflection of the nasal septum consists of a departure from its vertical position between the nares.

<sup>1</sup> Presented to the Section of Surgery and Gynæcology, June 1, 1905.

It is a deformity of mature age, being seldom seen in children, and is said to exist in about 75 per cent. of all adults. Fortunately for these, in many cases the deflection is but slight, so that not all so suffering are obliged to submit to operative treatment.

The deviation is more frequently to the left than to the right, and, in the writer's experience, more frequent in the male than in the female sex. No very satisfactory reason can be assigned for the latter circumstance, unless it be that youths and men are more liable to accidents leading to the displacement of the cartilaginous portion of the septum than girls and women. It is this portion that is usually involved, though the bony part may also share in the deformity.

One cause of septal deflection has just been referred to, namely, traumatism; and it often happens that a patient will give a history of a blow on the side of the nose during youth or early manhood, resulting in permanent lateral deformity of the whole nasal organ, or of the septum.

The more frequent cause of the defect, however, is to be looked for in the development of the nose.

As you know, the septum narium is built up of three parts: posteriorly, the vomer; superiorly, the descending plate of the ethmoid; and, anteriorly, the triangular cartilage, the first and last of these structures fitting into the bony ridge or crest of the palate bones as they meet in the middle line to form the floor of the nose. Thus the triangular cartilage is firmly wedged in above, behind and below by hard, unyielding bone, and it is easy to conceive that, if it should grow more rapidly than its bony surroundings, it must, in order to gain room for its development, be bent to the one or the other side.

A third probable cause may be found in the adenoid growths so frequently present in young children. In such cases, the mouth being often narrow and the arch of the palate unduly high, the nasal septum has not sufficient room to grow in the vertical position, and hence is pushed to one side.

Clinically, what one discovers on examining the nares by anterior rhinoscopy is that the septum, instead of divid-

ing the nasal cavity into two equal parts, projects in an angular or convex form into one or the other nostril, a corresponding deep concavity being observed on the other side. Grünwald states that the stenosis of the affected nostril is compensated by the greater width of the other one, and that thus the breathing is not greatly interfered with. His opinion is, however, quite opposed to the experience of patients suffering from this affection, and in offering it he appears to ignore the effect of reflex action on the respiratory centre, a consideration to which I shall have to allude more fully presently.

The deformity is sometimes sigmoid in form, that is, bent anteriorly to the one side, and posteriorly to the other, thus causing an obstruction in each nostril.

Of 2,152 skulls examined by the late Sir Morel Mackenzie, deviations existed in 1,657, or 76·9 per cent. Of these, 38·9 per cent. were to the left, and 28·2 per cent. to the right, while 9·5 per cent. were of the sigmoid variety.

#### COMPLICATIONS.

The complications attending or resulting from deviation of the septum, whether reflex or from obstruction to the breathing, are numerous. In the former category are to be noted chiefly asthma and spasmodic cough, due in extreme cases—as also in nasal polypus—to irritation of the nerves supplying the septum, by pressure on the latter, when deflected, by the middle turbinated bone. A sensitive area has been recognised in the septum, innervated by the fifth cranial nerve and branches from Meckel's ganglion. From these, an afferent impulse is conveyed to the respiratory centre in the medulla, and reflected thence to the trachea and lungs. (It may be mentioned here that I have found the reflex cough—especially that due to polypus—amenable to hyoscy. 3.) The asthmatical attacks are generally much worse at night, often causing the patient great suffering. This is due to the erectile character of the mucosa investing the turbinates, which becomes turgid when the patient is in the recumbent position, thus leading to increased obstruction.

As a result of mechanical obstacle to breathing, other consequences arise. One of these is mouth breathing, even where only one nostril is occluded, and the inspired air, not being warmed, as when drawn through the nares, renders the patient liable to attacks of bronchial catarrh.

The same obstruction prevents the discharge of mucus from the anterior nares, and so to the occurrence of post-nasal catarrh, and this, in its turn, to hoarseness, want of resonance of the voice, and nasal intonation.

In other cases, owing to the partial blocking of the inferior nasal meatus, the ventilation of the middle ear is defective and some degree of deafness may result.

All these complications, whether reflex or due to obstruction, can be relieved, as I hope to show, by suitable operative treatment.

#### CURE BY OPERATION.

An elementary principle in geometry is that the arc of a circle is greater than the chord subtending it, and that two sides of a triangle are together greater than its base.

A glance at the diagrams will suffice to demonstrate that this principle must underlie any operation that may be attempted for the correction of most cases of septal deformity. I say in most cases, because it will presently be seen that there is one exception to this rule.

It is obvious that the curved septum occupies a greater linear area than the normal vertical one. It therefore follows that in order to restore the former to the central position and keep it there, it is first necessary to reduce its linear dimension. Merely to bend it over to the middle line would be useless, as it would immediately fall back into its former position. The indication, then, is to incise the cartilage in such a manner that the fragments can be secured and induced to heal in an altered situation, and this object can be achieved in several ways.

The first operation I have to refer to does not fulfil these conditions, but the cases for which it is adapted are exceptional.

(1) It is known as Harrison Allen's, and is designed for those cases in which there is a straight or but slightly curved deflection of the septum above the anterior nasal spine, and a bend of the spine itself to the same side as the deflection.

The operation consists in dividing the frænum of the upper lip, and through the wound thus made a narrow chisel is introduced, and pushed upwards till the maxillary crest is reached. The shank is then raised till the cutting surface is opposite the crest, when, by means of a hammer, it is driven through the nasal spine as far as the nasopalatine foramen. The finger is then inserted into the occluded nostril, and the septum pushed over to the middle line. It is secured in this position, either by a nasal splint, or by gauze packing, till healing has taken place.

(2) The operation which is perhaps most in vogue at the present time is that known as Asch's, and is practically the same as one performed twenty years ago or more by Walsham. It consists essentially in making, by means of specially designed instruments, a crucial incision in the deflected cartilage at its point of greatest convexity. Each of the four fragments thus made is seized with forceps and twisted sufficiently to loosen it thoroughly, and thus overcome its resiliency. The four fragments are then pushed over into the middle line, and maintained there by a splint or gauze till healing is complete.

(3) A simpler operation, and one which I have found to fulfil all the desired conditions satisfactorily, may be described as a flap or valvular method. One advantage which it possesses is that it is available in cases when the stenosed nostril is so narrow that the cutting forceps used in the foregoing operation cannot be introduced.

To perform it, a narrow-bladed scalpel is inserted into the inferior meatus of the nostril beneath the base of the deflection, and the mucous membrane incised in an anteroposterior direction. A Bosworth's saw is next passed into the incision thus made, and the cartilage sawn through in an inward and upward direction till the blade can be felt with the finger in the opposite nostril. It is then turned



upwards into a completely vertical position, and the incision continued till the vertical position of the septum is reached, a valve-like flap, with its base intact, being thus formed. Lastly, the flap is pushed through the opening that has been made in the septum, towards the other nostril, and its edges, catching in that position, heal there permanently. The latter performance can be aided, if necessary, by the blades of an Adams' forceps inserted one into each nostril.

These measures having been carried out, the operator's little finger can be pushed right through the nares into the naso-pharynx, and he can thus satisfy himself that the parts have been properly adjusted. The result of the operation is to provide permanent and adequate breath-way through the previously stenosed nostril, while the redundant concavity on the other side is partly filled up. After the operation, a hollow splint is inserted into the affected nostril, and healing is generally complete in about a fortnight. Where nasal splints or plugs are badly tolerated I have found plugging with gauze quite efficient if changed every two or three days.

(4) In a few cases where the deviation is unusually high up in the nostril, and in the form of the apex of a triangle, the foregoing operations may be impracticable. Here, the simplest way of giving permanent relief is to amputate the projecting apex, a perforation of the septum being thus established. A small portion of cartilage only need be removed, as, after healing has occurred, cicatricial contraction of the mucous membrane round the edges of the wound occurs, and the opening thus tends to enlarge in process of time. The result of this procedure is all that can be desired, a very satisfactory breath-way being permanently secured.

In all these different methods an important point in technique should be observed, namely, the prevention of hæmorrhage during the operation. This can be done efficiently by spraying the nares with equal parts of adrenalin, 1-1,000, and a 10 per cent. solution of cocaine, and then packing them for a quarter of an hour before the operation with cotton-wool or gauze, soaked in the same

solution. By this means the operation can be performed with little or no bleeding, and any reactionary hæmorrhage is controlled by subsequent plugging.

#### ILLUSTRATIVE CASES.

(1) The first case to which I have to refer in illustration of the foregoing remarks is that of a man, R. P., aged 32, who applied for advice in the spring of 1902, on account of a long-standing difficulty of nasal breathing, and asthmatical symptoms. He described his nights as very distressing, the difficulty being then so increased as to disturb his sleep seriously. Whenever he took cold his symptoms, of course, became still more marked. The result of this condition had been to impair his general health, a circumstance to which his worn appearance bore ample testimony. Examination of the nares, which were both relatively narrow, revealed almost complete stenosis of the left side, due to a deflected septum which lay in contact with the middle turbinate. Operation was advised, and carried out under general anæsthesia. The projecting angle of the septum was found to be so acute that the only practicable proceeding seemed to be to remove the apex entirely. This was accordingly done, the result being a perforation communicating with the opposite side. Healing having taken place, the patient soon began to experience great relief in breathing, his sleep became more natural, and general health improved. I had the satisfaction of seeing him about a month ago, when he stated that he had felt a different man ever since the operation, and had gained over half a stone in weight.

(2) Mr. B. aged 40, seen first July 21, 1903. This patient also complained of difficulty in breathing, and of partial deafness on the left side, which interfered considerably with his duties as superintendent of a large industrial school. Hearing could be improved temporarily by auto-inflation of the tympanum. The objective signs of catarrh of the middle ear were present, the membrana tympani being flaccid and retracted.

On the same side as the deafness there was a marked deviation of the nasal septum.

The patient having been sent into a nursing home, on July 27, the flap operation already described was performed quickly and easily, and with scarcely any hæmorrhage. The detached portion of the septum thereafter healed satisfactorily in its new

position, and, the breath-way having been thus re-established, a marked improvement in hearing took place. This patient has also been seen within the last few months, and the cure appears to be permanent.

(3) Mr. H. E. P., aged 58, came for advice on September 6, 1902, on account of frequent attacks of bronchial catarrh, and, in describing his symptoms, he mentioned that the left nostril often became blocked up at night, and that he had been operated on for polypus on that side. My notes state that "the septum is much deflected to the left, and there is a small spur at the bottom of the right side. Bronchial râles are present in the upper half of the left lung." The latter condition had in the first place to be got rid of, and cleared up under ipecac., ars. iod., &c. In the February of the following year he reported himself as much better as to the chest, but the nasal stenosis was a great source of discomfort.

On the 24th the septal deviation was corrected, the same procedure being carried out as in Case 2, and with a like favourable result. On July 14 following, I received a letter from this patient, who lived at a distance, stating that the operation had been very successful, and that he had not felt so well for years.

(4) In this case the patient was a young lady, Miss B., aged 21, and was seen towards the end of 1903, on account of difficult nasal breathing, post-nasal catarrh, and impairment of the voice. She was accustomed to sing in public, and found that her voice was lacking in resonance, and that she had difficulty in producing some notes.

Her case was somewhat remarkable, as during childhood she had met with an accident causing fracture of the bridge of the nose, with a very unsightly deformity as a result. The previous summer, when in Scotland, she had consulted a specialist on account of this deformity, and he had corrected it by means of a hypodermic injection of paraffin. The result, however, was a nasal feature of somewhat Wellingtonian proportions, and evidently the injection had been overdone.

On examining her nostrils, I found a septal deviation, this time to the right side. On January 12, 1904, the flap operation was performed, the results ultimately being all that could be desired, in removing the post-nasal catarrh, and in improving the quality of the voice.

(5) The last case I have to mention is that of the patient already shown here this evening, K. MacK., on whom I performed the flap operation on May 19 of this year.

The obstruction was, as is most frequently the case, on the left side, and had occasioned post-nasal catarrh and difficulty of breathing, especially during eating, as he found it impracticable to perform both functions by the mouth, and at the same time, in a satisfactory manner. I trust you have been able to satisfy yourselves as to the effect of the operation.

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Mr. DUDLEY WRIGHT pointed out that the brain, in developing, had a very much easier task in growing upwards than in growing downwards, and that the want of union of the upper part of the bones of the head enabled the brain to expand in the upper direction, whereas the very early union of the parts below would prevent the brain from expanding downwards. He thought that they had an even better explanation of deflected septum than growth of the brain in the development, generally, of the face. He did not think that there had been attributed to the development of the face as much importance as was really due. When the bones thoroughly expanded and the palate became broadened out, there was plenty of room for the septum to grow downwards. It was a question of the septum growing downwards and forwards. If, for any reason, the cheeks did not expand and the arch was pinched in, they would have, of necessity, a very arched palate, and that would inevitably press up, or prevent the down-growth of the septum, and the septum had to bulge on one side in order to make up for the arched palate. That brought him to another point—the question of why the palate did not develop and why the bones of the face did not spread out. It was well known that a deflected septum was very rarely found among savages. They had to look upon it as a disease of civilisation, and he thought that, perhaps, there were two or three factors which caused it; first, the method of eating and the kind of food eaten; secondly, the general tendency to the narrowing of the face in the more civilised classes; and thirdly, the use of the pocket-handkerchief. First, with regard to food: Savages always ate very coarse, hard food, and in eating it they exercised the muscles of their face, and this of itself was a great stimulus to the growth and proper expansion of the facial bones. The proper expansion of the facial bones was one of the most important causes in preventing the deflection of the septum. Then with regard to the second cause: They knew that the nervous diathesis had a great effect in narrowing the bones of the face and producing a long chin, and it was just the patients in which this occurred who suffered from the deflected septum. This raised another point with regard to

asthma. He had for a long time doubted whether pressure on the nerves of the septum was the real cause of the asthma. He thought that it was very likely that asthma might be much more due to the nervous diathesis than was supposed. The third cause which he had suggested was the blowing of the nose with the handkerchief. If they watched an ordinary child blowing his nose, they would see him holding his nose with his right hand and moving it from side to side. This was a point which would have to be attended to in the prevention of this deformity. A child must be taught how to blow his nose. Prevention was better than cure. It would be found that in a great many children the first stage of the deflection was present, and the object should be to prevent its getting worse. It was, however, of no use to operate on a young person before the bones were consolidated, for, if the deformity were corrected then, it would be almost certain to come back again. A means of preventing it from getting worse would be to get the children into the practice of deep breathing, and also teaching them how to blow their noses properly. Of course, the proper way was to grasp the bridge of the nose and put the handkerchief underneath. The first operation which he performed on a deflected septum was carried out some years ago, and the patient was a middle-aged lady. After cutting through the deflection, he put on a clamp which he had bought for the purpose, and clamped both sides together very tightly, and in four days he found that the clamp had made a huge perforation in the septum. He was rather alarmed at the time, but the patient was very much relieved, and no bad result followed the perforation. The patient had previously suffered from extremely bad headaches, and soon after the operation the headaches ceased, and the patient went on very well. The only thing was that a small crust of mucus used to form on the perforated septum. There was no fear of the bridge of the nose falling in under such circumstances.

Dr. GOLDSBROUGH said that with regard to the causation of the deflected condition, he wished to ask whether deflected septum was usually associated with a high palatine arch. There was no doubt that a high and narrow arch was an evidence of degeneracy. People who had broad projecting ears and a narrow forehead were subject to degenerative disease of the brain. This was a very important point, evidently, in the causation of the condition of deflection, and one which required to be cleared up by observation. Mr. Wright had raised the point, but neither he nor Dr. Alexander

had said whether the condition of the high arch was associated with the deflected septum.

Dr. MADDEN asked whether the condition of deflected septum was not usually associated with chronic mucous thickening.

Dr. BYRES MOIR said that an old college friend of his who had charge of an asylum wrote a paper on the high arch of idiots. In idiots they got the highest arched condition of the palate.

The PRESIDENT said that he hoped that Dr. Alexander would feel from the very interesting discussion that the Society had duly appreciated his paper. If Dr. Goldsbrough's suggestions from Mr. Wright's premises were correct, flap ears were to be associated with deflected septum as a sign of degeneracy. The treatment for flap ears, was to remove a piece of the cartilage entirely, and he saw no reason why surgeons should not adopt that method a little more frequently, in the case of deflected septum.

Dr. SPEIRS ALEXANDER, in reply, said that he felt quite satisfied with the discussion. A punch forceps had been devised for removing a portion of the septum. There was no objection to the operation, though he supposed that it was an axiom in surgery that they should be as conservative as possible, and not remove tissue unless it were necessary. But if a perforation was established, it was seldom followed by any unfavourable result. As to the non-existence of the deformity in savages, he was not in a position to make any remarks, for he had not had any opportunity of examining savage races. He thought that the asthma was undoubtedly due to the pressure on the septum in the sensitive nerve area that he had already mentioned. That was proved, he thought, by the fact that after the operation had been performed the asthma had ceased. With regard to the high arching of the palate, the consideration was a very interesting one, but he was not sure that this had been recognised definitely in cases of deflected septum. He was inclined to think that the conclusion with regard to this matter was a theoretical one, rather than the result of clinical observation. They found high arch in children with adenoids, and it was very likely that it was one of the causes, but he did not think that it was associated with all cases with deflected septum. He would in future pay more attention to observing whether flap ear was associated with deflected septum. Mucous catarrh was present in some cases, but he thought it was an effect rather than a cause.

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SOME POINTS IN THE CONSIDERATION AND TREATMENT OF EPILEPSY.<sup>1</sup>

BY GILES F. GOLDSBROUGH, M.D.

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IN attempting to introduce for discussion the formidable subject of epilepsy, I feel a diffidence which seems to be due to several impelled limitations in any prospective treatment of it. First of all, I want to make my communication interesting and to avoid the ordinary text-book plan usually adopted in the description of a disease. Secondly, aim in accuracy of description appears as an essential if the element of interest is to be kept up, and at the same time a contribution is to have any practical bearing in treatment. Thirdly, the time at my disposal has been very short for the preparation of a paper on a subject which, even in this day of advanced knowledge in other diseases, is still obscure in its causation and pathology, and considerably varied in its clinical features. Indeed, in this respect I could not have ventured to present a communication on the subject at all without the valued co-operation of Dr. Margaret Tyler, to whom I am deeply indebted. Dr. Tyler has very kindly looked through all my out-patient note-books and indexed every case of epilepsy which has been presented in my out-patient clinic at the London Homœopathic Hospital for years past. Fourthly, although I have given a good deal of attention to the subject, up to this point I feel that all my efforts hitherto have been but tentative, and the evidence I have collected shows that knowledge is brought but to a certain point, a point, I trust, which may be at the same time a dividing line between what in the past has been tentative and what in the future it is desired may be more certain, the actual dividing line being the grace or favour of the opportunity of presenting the imperfect knowledge and effort of the past to

<sup>1</sup> Presented to the Section of General Medicine and Pathology, June 28, 1905.



the notice and discussion of professional brethren and friends met for a consideration of the subject.

### I.—DIVISION OF THE SUBJECT.

For the purpose of bringing out the chief features calling for attention, and on which I wish to lay emphasis, I need a basis for my remarks in a concise definition of the disease, and for this purpose I cannot do better than quote the short description given in the Sydenham Society's "Lexicon."

The term *epilepsy* is derived from the Greek verb ἐπιλαμβάνω, to lay hold of, to seize, and the disease is described as follows: "A non-febrile nervous affection characterised by attacks or fits of sudden and temporary loss of consciousness or disturbance of the mind, and tonic or clonic convulsions lasting for a more or less short period, and occurring at irregular intervals. The phenomena constituting the epileptic fit vary indefinitely in severity and in character, the typical and more severe being true epilepsy, *grand* or *haut mal* of the French, the defective and less severe being the *petit mal*, epileptic vertigo, or abortive epilepsy, of English authors. A typical epileptic fit is usually preceded by some premonitory phenomena, the so-called epileptic aura, irascibility of temper, coldness of the feet, muscular cramp, giddiness, sensorial illusions, and such like, but the attack itself is sudden; generally the sufferer becomes pale, loses consciousness, utters a cry, falls down, the muscles of one side or of the whole of the body slowly contract and become rigid, the breathing is stopped until lividity of the face and distension of the veins of the head and neck occur; then there are clonic, often unilateral, convulsions of the muscles, frequently accompanied by biting of the tongue, evacuation of the contents of the bladder or of the bowels, stertorous breathing, and violent action of the heart; in a short time, a minute or two, as the breathing is restored, the convulsions cease, the blueness of the face passes off, the limbs become flaccid, and consciousness returns, either speedily or after a longer or shorter interval of stupor or coma, or of intellectual disturbance, and is followed before complete



restoration by great weariness and aching of the limbs and the head, or the coma may proceed to death. At the other extreme the fit is represented by a passing giddiness, a temporary loss of consciousness or of memory, a fleeting spasm of some muscles or set of muscles, a delusion<sup>1</sup> of one or more of the senses, a sensation of sickness or of faintness, or of some other representative of one of the other representatives of the complete attacks, and between these two there are infinite gradations."

This is the description. The most obvious next reflection from the occurrence of an attack of epilepsy is a reference to the pathological cause, and, as is well known, medical literature is full of much speculation and some well-established fact in reference thereto.

The facts of knowledge up to date lead to a classification of the cases into two divisions, namely, idiopathic and symptomatic, but the terminology of this division reflects rather upon ignorance than knowledge of pathological causation. The actual state of the brain in a case of epilepsy is unknown, but a certain class of cases occur in which the clinical manifestation of the attack can be referred to some state altered from the normal, such as an old cortical softening, a depressed spiculum of bone, a scar following hæmorrhage, or a new growth. Where such a condition can be diagnosed the actual occurrence of epileptic seizures is then termed symptomatic, leaving over the large class of cases which cannot be referred to any particular organic lesion to be termed idiopathic. Owing to the satisfaction they afford to the scientific imagination, the greater variety they present in their symptomatology and their more probable amenity to treatment from the surgical point of view, the former class of cases are a more interesting class than those not presenting these conspicuous features. But, as I am under the necessity of limiting my paper on the present occasion to a reasonable length for the allowance of discussion, I must deny myself the pleasure of bringing before you cases of the symptomatic class, and confine my attention to the less interesting cases known as idiopathic. I am anxious

<sup>1</sup> I should think this must mean illusion.

on this occasion to present the problem of epilepsy in its right light. It will be seen that this problem awaits a solution from the point of view of causation, in the more practical bearing of preventive medicine, in the light the seizures are to be regarded from the nosological point of view, their occurrence and recurrence from the point of view of the physiology of the brain, and from anticipation of the treatment of a patient who is a victim of the attacks. Remembering, then, that all so-called symptomatic cases are to be excluded, I may proceed at once to make a few observations on the theory of the attack.

## II.—THEORY OF THE ATTACK.

The most common attempt to bring the phenomena of an epileptic seizure under some more general conception or idea of its nature than that of convulsion consists in a description of it as a liberation of nervous force or energy. All observations and experiments that have been made in reference to this or allied phenomena go to prove that the cerebral cortex is the anatomical seat of the initiation of the disturbance, the discharge taking place through the centrifugal paths and peripheral nerves, culminating first in spasm, then in complete relaxation of muscular contraction. It goes without saying that the contraction or spasm is the characteristic feature of the disturbance, relaxation being exhaustion or a negative state secondary to that. But, as Gowers well points out,<sup>1</sup> liberation of energy is not the only phase of the motor function of the cerebral cortex, and that, therefore, the epileptic paroxysm cannot be regarded merely as excess in the liberation of nervous force. Restraint of energy, or resistance to its liberation, is quite as much a function of the cerebral cortex as is the liberation of energy. Resistance to or control of action is quite as essential to the co-ordination of voluntary movement as is the initiation of movement. So that from the physical side of the picture an epileptic paroxysm can be looked upon as defective restraint quite as much as it can be regarded as

<sup>1</sup> "Diseases of the Nervous System," 2nd Ed., vol. ii., p. 755.

excess in the liberation of nervous force, and the crux of a theory of the paroxysm consists in the attempt to localise or explain this as a disturbance of the function of the cerebral cortex. From the point of view of liberation of energy the epileptic paroxysm can be looked upon as as complete discharge of muscular contraction of the whole body as a liberation of the total energy of the body is capable of. And, likewise, from the point of view of restraint of energy, the paroxysm can be looked upon as as complete an absence of restraint as in normal volitional exercise is regularly and co-ordinately exercised with reference to the purpose of the organism in the initiation of any particular movement. If this is so, the conception of muscular force as a manifestation of energy is only partially true, the greater energy consisting in restraint or co-ordination of movement.

This leads us to turn from the physical to the mental side of the picture, and it seems impossible to avoid some reference to the metaphysical aspect of the subject. It is evident that in attempting to form a true conception of an epileptic paroxysm we must take into consideration the intimate relation of mental and brain states. And in any attempt to discuss morbid conditions in which both brain and mind are involved, it is absolutely essential that both physical and mental sides of the picture should be considered and the endeavour made to correlate them.

The instantaneous derangement of any function of any part of the brain appears incompatible with the integrity of consciousness, and, if incompatible with the integrity of consciousness, necessarily incompatible with the exercise of any deliberative movement or deliberative restraint of movement of the voluntary muscles. Both actual consciousness and deliberation as secondary to consciousness are to be looked upon as functions of the cerebral cortex as an organic whole. Deliberative thought most likely has its localisation in the frontal lobes. The initiation of movement in its various complexities in bi- and unilateral relations of the Rolandic regions. Thus, the occurrence of an epileptic paroxysm is to be regarded as a disturbance of the whole of all these regions, although in some cases, and in minor

attacks, symptoms are presented in which parts only apparently are to be referred to.

In the present connection the fact of consciousness is to be regarded as a state of the brain involving a continuous temporary production of some sensory function of the most comprehensive kind, in relation with which deliberative thought, initiation, or restraint, or both, of movement takes place. Both the fine reflexion of feeling as consciousness and the intention of thought as deliberation have reference to the purpose and ends of the organism as a whole, and the latter is not exercised without the former.

In reference to the ends of the organism as a purposive being, deliberative thought as intention, initiation, or restraint, or co-ordination of movement, and not consciousness, appears as the essential function, consciousness being given as an accompaniment if movements are to be initiated or restrained co-ordinately to the purposes and existence of the organism.

From the mental side of the picture the integrity of consciousness is not the primary function which has to be taken into consideration in reference to liberation or restraint of energy as the distinctive feature of an epileptic paroxysm. Stated more fully from the mental or personal side, my argument as to the theory of epilepsy is as follows. Admitting the anatomical basis of the disturbance which constitutes the paroxysm, I submit that a conception of it either as a liberation or absence of restraint of nervous force is inadequate. Although these are its manifest physical features, rather is it to be regarded as a disturbance of the finest equilibrium between the integrity of the mind as the controlling function of the whole personality in the intimate relation of this function with the muscular system of the bodily organism. Inasmuch as the voluntary muscular system of the whole body is concerned with the purpose of the organism as a living, thinking being, if a disturbance through irritation or any other cause takes place, if the equilibrium between the highest controlling function and the lower active or energetic function in the sense of a weakening of the former, just in the central

co-ordinating area between them, disturbance of the latter would obviously be so great as to involve an exertion or exhaustion of the whole capacity for action, with the subsequent relaxation of the whole muscular system. In other words, an epileptic paroxysm is to be regarded as the result of a disturbance in the equilibrium of the whole organism, as an organism controlled at all by a presiding central nervous mechanism. The real disturbance is just at the centre for the co-ordination of the whole of movement as distinct from movements in particular or in part. And as the central control is deranged or removed, so the disturbance becomes one of the fullest exertion of movement without control. Only in the light of such a comprehensive theory can the operation of all the factors of causation be explained and a view of the paroxysm as a feature of disease calling for prognosis, prevention, or treatment, be adequately appreciated. Epilepsy is an ailment occurring at all ages, and appears to result directly or indirectly from nearly all known factors in disease production. Heredity, developmental irregularities, syphilis, tuberculosis, rickets, reflex irritations, instability of cortical centres, injury, mental over-strain or anxiety, emotional disturbance, toxæmia, all appear in the field of its causation. A comprehensive theory of the occurrence of the paroxysm is also essential to an explanation of its recurrence when once established, and to its relatively slight amenability to treatment. From this point of view it may be remarked that the equilibrium between the highest control of the voluntary active system of the body with the lower initiative system is of so fine a nature that if the first is defective or lost it gives the rein to the second, and cannot regain it. On the other hand, the organic system of the lower is so true to the continuance and purpose of the organism that when once the new path of morbid action is opened and set up, control having been effectively weakened, action along that path recurs at intervals according to idiosyncrasy and law while life is prolonged. Thus it comes about that for an adequate conception of the ailment in its whole occurrence and recurrence to be formed, two generalisations or conceptions of it have

to be borne in mind. The initial cause and the occurrence of the first fit are to be regarded as the disease. Every recurrence, with all that each fit means in its effect upon the future of the mental or physical state of the patient, unless the primary cause is totally removed, is to be regarded as a recurrence of the original disease. If the primary cause is totally removed, recurrence has a significance alone of idiosyncrasy or of the law of habit of the nervous system, a perpetuation of the loss of control, and the initiation of a new path of perversion of function. Under the heading of "Theory" I have not time to quote cases illustrative of the emphasis I wish to lay on the necessity of more than a merely physical theory of the disease. Nothing short of an adjustment of the physiological and psychological aspects of the seizure can be adequate as a theory of it, and I must trust to the cases brought forward later to support this view. It will be sufficient here for me to reiterate that in the occurrence of the seizure we have an intricate biological and psychological problem awaiting solution. In the meanwhile we are confronted with the problems of prevention and cure.

### III.—A RECENT STATISTICAL ENQUIRY.

Towards a solution of the problems of prognosis and cure, Dr. Aldren Turner, of the Queen Square Hospital, has recently published<sup>1</sup> the results of an enquiry on these points based on 366 cases, mostly out-patients who had been treated at that hospital. These cases were all of the idiopathic class, and with the exception of one or two were all given the bromide treatment. The results of the enquiry thus form a very good basis of comparison with other modes of treatment, and, in the light of a comprehensive theory of the seizures, are critically suggestive of several principles to be borne in mind for prevention. In the short time at my disposal I can, of course, only give details of Dr. Turner's method of enquiry and its results, leaving out most of the figures for any one who cares to refer to his paper on

<sup>1</sup> *Medical Press and Circular*, June 17, and 24, 1903.

the subject. As regards method, he excludes all cases which had not been two or more years under treatment. Then the cases are accepted as a whole, and divided not according to their individuality, but on the principle of occurrence of causal factors of a general biological nature, such as age, marriage, &c., and not according to the presence or otherwise of previous disease. In results the cases are divided into three classes, those in which the seizures were arrested by treatment, those that were improved, and those in which the attacks became confirmed. Two years without a fit is the period allowed to lapse before a case is included under the class of arrested cases. Results are also given in cases under treatment nine years. All results are stated in percentages. This, in brief, is an outline of the method employed in the enquiry, and the following are the general results of the investigation.

Total cases 366.

(1) *As to duration*.—Two years and upwards, arrested 86, improved 105, confirmed 175; nine years, arrested 38, improved 43, confirmed 66.

(1a) Duration affects prognosis, arrest is more likely during the first five years, although it may occur after twenty to thirty years' duration.

(2) *Age* is important in prognosis. The occurrence of the fits under 10 years of age are the least hopeful for arrest. (Under homœopathic treatment when a sufficient number of cases are collected, I do not think this conclusion will be borne out. My reason for this opinion I hope will appear in the sequel.) From 15 to 20 there is about an equal expectation of arrest or confirmation. From 20 to 30 and after 35 there is a greater expectation of arrest. Between 30 and 35, next to those under 10, there is a greater expectation of confirmation.

(3) There is usually a *family history* among confirmed cases, but heredity does not appear to militate against arrest or improvement.

(4) From the point of view of *regularity or otherwise of recurrence* and frequency, the more frequent the less likely is arrest, especially with regard to daily or weekly recurrence as comparable with yearly.



(5) As regards *severity*, major attacks are more tractable, then combined major and minor.

(6) *Marriage* has little effect, also pregnancy, but the puerperium and lactation seem to favour the occurrence of the fits.

(7) Long *remissions* may occur, especially in the first ten years of life, so that nine years should be accepted as the basis for cure, and on this basis 10·2 per cent. of cases can be accepted as cured. In cases arrested cessation of the fits occurs during the first year of treatment in 50 per cent.

(8) Cases susceptible of cure present no mental impairment. On the other hand, in cured cases various mental peculiarities usually manifest themselves, such as impairment of memory, irritability of temper, headache, and a tendency to neurasthenic symptoms.

#### IV.—EXPERIENCE AT THE LONDON HOMŒOPATHIC HOSPITAL.

Since the inauguration of the Department for Diseases of the Nervous System at the London Homœopathic Hospital about 115 cases of idiopathic epilepsy have presented themselves for treatment. The department has been in existence for seven years. A few of the cases included were in attendance before the special attendance for nervous diseases was commenced, so that the number given represents practically all cases that have been under my care since I joined the staff of the hospital. In anticipation of a presentation of the results of treatment of these cases I must first mention the fact that a large number of them, I should think about a third, only came to the hospital once. A fair number also only came twice, and a few three times only. These facts should, I think, be taken seriously into account, and an explanation of them be forthcoming. Rightly or wrongly, I have attributed the cessation of attendance, after from one to three visits, to two or three circumstances. First, a good many of the cases have been confirmed cases, who have come from other hospitals, and I imagine have anticipated some



striking and remarkable result from the treatment at the Homœopathic Hospital which they have not previously received at other hospitals. As a matter of principle, and for the purpose of the development of the homœopathic treatment of epilepsy in all but about two cases, I have studiously refrained from giving bromide in any form, and when patients have come and not received the accustomed medicine with a strong flavour and decided sedative effect on the brain, I imagine they have become frightened or sceptical as to the probable results of the new treatment, and so have not put in an appearance again. I should like to say that patients who have continued in their attendance, and who have previously been under the bromide treatment, as a general rule have not suffered from the want of it, but on the contrary, even though the number of attacks might not have diminished, the general health has improved, which I have attributed partly to the absence of bromide, and partly to the homœopathic treatment they had received. In a certain number, just a few no doubt, the effect of treatment has been of immediate benefit, and further attendance has not been thought necessary. A case in point of this kind was brought to my notice only a day or two ago. In the details of cases which follow I shall leave you to judge of the value of the treatment that has been adopted; but at this point I wish to say that owing to the cessation of attendance after from one to three visits of so large a number, and the short time the department has existed as a special department, and the really tentative view of the disease which present knowledge obliges us to take, I have not attempted to tabulate my cases, but I have selected a number to present in detail, in which the majority of features of the disease are illustrated, in which homœopathic medicines appear to have had effect, or appear to have failed.

By this means I hope to suggest, not immediately that treatment by the homœopathic plan shows superior results to the bromide treatment, but that a view of the disease, regarding it as a clinical entity, is an erroneous one, and that a rule of thumb administration of one drug as a seda-

tive cannot be the last word to be said in the treatment of epilepsy. A more or less permanent arrest of the fits in 10·2 per cent. of all cases presenting themselves probably represents the high-water mark of the bromide treatment, and in many of these cases it is acknowledged that a permanent morbid nervous state is left behind. My own percentage of arrest may not be even so high as 10 per cent. of the cases presenting themselves; I do not know, as I have not estimated my results in this or in any other way. But what I do wish my cases to point to is the necessity for the consideration of one case at a time, and the various principles involved in an anticipated prevention of the occurrence of the seizures, in an attempt to prevent recurrence of the first fit, and in the prevention of the occurrence of an attack in any event as first or last, that is, the prevention of occurrence of the malady in any event.

*Case 1.*—A male, aged 13, came on April 26, 1896. Had been subject to attacks of feverishness preceded by convulsions. Had suffered from convulsions in infancy, and fright at school. Had two attacks in the past three weeks. I have no notes of the supposed cause of the feverish attacks, or of instructions given to prevent them, but have no doubt these points were enquired into. The patient was given acid. hydrocyanicum 6. He came five times until June 11, and had one attack after his first attendance. He appeared much brighter and better.

This case is quoted as one which would easily become a confirmed epileptic. Had the attacks recurred further attendance would no doubt have been given, and the case illustrates the need for search of the cause of the first fit.

*Case 2.*—E. F., aged 18, female, domestic servant, came on December 3, 1896, and has been under treatment ever since. The first fit occurred in March, 1895, with irregular recurrence since, and latterly, up till the time of first attendance, four in a month. At the time of the occurrence of the first fit menstruation had ceased for eleven months, due, it was thought, to exposure to wet. When the patient came she had been "regular" again for ten months, but with scanty discharge, and the occurrence of severe headache and bilious attacks during the period. The girl is good tempered, with a placid disposition. The "fits" are of

the major variety, preceded by an aura of weakness and jerking of the limbs. She was put on pulsatilla 30, and lower dilutions with a dose of belladonna at night. The attacks began to alter directly under the treatment. They became much reduced in frequency, although in eight and a half years' treatment they have not ceased. The longest period she has gone without a fit has been from three to five months. At the present time they occur about once in two months. The state of menstrual discharge has improved. But, what I consider most important of all, there has been no apparent mental impairment owing to the fits. The patient has, however, suffered much from attacks of migraine, and sometimes from jerking of the limbs as if a fit were coming on. She has not been able to continue in her employment. The medicine has been changed at intervals, she receiving at times iris, ignatia, cuprum, sulph., œnanthe, senecio, and latterly bufo, but pulsatilla in the day and belladonna at night have been the remedies mostly used.

A word here on the use of bufo. I have been disappointed in this remedy, which is reputed to be useful when the fits occur about the time of puberty, and are associated with scanty or suppressed menstruation. In a private case, some years ago, I gave this remedy as it seemed completely indicated, and it did not appear to have the slightest effect; nor, indeed, did other drugs, for the girl has become a confirmed epileptic, and has had one attack of acute mania, lasting some months.

*Case 3.*—B., a female, aged 22, had been suffering from *petit mal* for nine years, believed to have been caused by fright. The attacks occur one to three times a day. She stands still in the street, and does not respond to any stimulus. Is not convulsed, except rarely. Always wants to sleep afterwards. She came three times in 1897 and was much improved under ignatia 12.

*Case 4.*—C. S., a male, aged 11, came in February, 1898, and continued attendance until October. Had been suffering severely for two years, and under treatment at the National Hospital and at Paddington. Seizures began with *petit mal* five years ago, and the *grand mal* had been two years. The character of the attacks at present consists of pallor, lividity, loss of consciousness with convulsions, occasionally followed sometimes by a maniacal condition. Has always been a sleepless child. Complains of headache in the forehead, temples, and vertex, throbbing and as

in a vice. Has slight phimosis. He was put and kept under zincum 12 t.d., with a dose of belladonna 30 at night, and was apparently cured. In July, 1901, the mother wrote me that he had had no attack that year, and had gradually improved in health since his last visit.

I here introduce a private case, which illustrates the causation of the fits by reflex irritation, and the value of zincum as a remedy.

*Case 5* is that of W., aged 7, a nervous, excitable child, brought to me in 1902 on account of threatening chorea. I found him suffering from phimosis, which was rectified by circumcision at my request, and he received zincum sulphatis 12. Some months afterwards he had an epileptic fit, which was immediately followed by vomiting of food, evidently undigested. I prescribed for this in 1903, giving zincum 12 and a very strict diet, no animal food, and a particular avoidance of irritating substances, such as currants or seeds of any kind, and an injunction to masticate thoroughly. The child had another fit a few weeks afterwards, due again, as I thought, to reflex stomach irritation, but not since. He continued the zincum for some months. I saw him the week before last, and he appeared well, although rather excitable.

I would draw attention here to the mental symptoms in the pathogenesis of zincum, as being highly characteristic and important. The patient is emotionally excitable, irritable, morose, or peevish, but intellectually is dull and forgetful. I believe the mental contrast in the pathogenesis is a valuable indication for the use of this medicine.

*Case 6.*—E. P., aged 18, female, dressmaker, came in October, 1898. She is hysterical, deaf, and has *petit mal*. Has three or four attacks a day, occurring once in two or three weeks. Pallor, twitching, clenched hands, does not quite lose consciousness. Hears a watch close to the right ear, not at all by the left. No report of a special examination of the ears. She was given pulsatilla 3 t.d. and moschus 1 if she felt the attacks coming on. Her hearing improved to 2 ins. She had one attack in December, and continued her attendance until February.

It might be contended that this was not epilepsy, but hysteria; but in reply to that I should say sometimes the differential diagnosis is extremely difficult, and the occur-

rence of pallor and twitchings at the beginning of the attack is in favour of *petit mal*.

I now wish to mention four cases in which the medicines used appeared to have no effect whatever on the recurrence of the fits.

*Cases 7 to 10.*—A. R., aged 17, male, a joiner, had fits, which appeared to follow influenza. He improved in health under belladonna, but there was no reduction in the frequency of the attacks.

A. E. G., aged 30, female, telegraphist, had been suffering eleven years with *grand mal*. She got steadily worse under plumbum and opium.

A. D., aged 17, male, suffered since infancy. No effect from zincum 3 t.d. and belladonna at night.

O. E., aged 18, male, suffered for twelve years. One or two attacks a week. Thought to be due to injury. Fits one or two in a week. He received zincum 3x, and came from March 13 to May 16, 1899.

I have a good many cases of the kind included in these three. I will mention two more and pass to some that are more interesting.

*Case 11.*—K. F., aged 20, married, attended in March, 1899, suffering from fits which came on during pregnancy two years before. She received stannum and belladonna without effect.

In this connection I should like to say that in epilepsy during pregnancy I think the use of bromide is both justifiable and called for.

In *Case 12*, which I attended in consultation with Dr. Vincent Green two or three years ago, the patient, aged 26, had suffered from epilepsy and melancholia. The attacks began at 10 years of age, were attributed to grief; always occurred at night. She was very depressed and fearful, also suffered from loss of memory. Under Sir W. Gowers she had received pot. brom. gr. xv., ammon. brom. gr. xx., tr. belladonna m̄vii., sodæ biborate gr. iv. in syrup of orange and water ʒss. as a dose for the night, and half the dose in the morning, which appeared to control the fits. She had gone a year without an attack. She had an attack of insanity after the first child was born. She came to Dr. Green with an attack of gastritis, thought to be due to the

medicine. It was left off and the epileptic seizures returned. I prescribed valerianate of zinc at first, afterwards cicuta, sepia, sulphur, and belladonna. The fits were held somewhat in check, but the patient was very frightened of their recurrence, so I prescribed seven grains of potassium bromide as a dose to be given occasionally. Eventually, pregnancy ensued, and the more or less regular use of the drug was found necessary to control the attacks. I believe the patient has come successfully through the ordeal of childbirth again without a decided attack of melancholia, but I cannot speak definitely of her state at the present time.

*Case 13.*—A. K., aged 25, female, milliner, dark, had suffered for three years. She came in August, 1899. She has an attack of *grand mal* once in three or four months, but a number of minor attacks daily of slight flushing of the face, excitability, depression and headache. She receives ignatia 3x. to 12, and belladonna at night. The length of interval between the major attacks was increased by the treatment. She had no fit from November 16 until March 2, and not again until November 17 following. In the intervals, however, her general nervous state was not satisfactory. She suffered much from attacks of flushing, fear, sleeplessness and dreamy states. Instead of belladonna I had given her hyoscyamus, atropine, and on one or two occasions potassium bromide, grains v. After November, 1900, she received ignatia again. The next fit was January, 1901, then April 8, November 13, and January 2, 1902. She received valerian and moschus occasionally during these months, also sepia. Her last attendance was in February, 1903. I was very disappointed with the result in this case, but have to remark, which is usual in a good many cases, that the patient seemed better in health when the fits occurred. The constant apprehension that an attack was impending as the interval became lengthened was greater suffering than its actual occurrence.

*Case 14.*—In this case we have a remarkable combination of hysteria and epilepsy, a case resembling in many respects the hysterio-epilepsy of French writers. It is that of M. R., aged 18, female, no occupation. Came on September, 1899. Has suffered for three years. Has three or four major attacks every night. Her mental state is very peculiar. She volunteers no information except in one particular to be mentioned immediately. But she answers questions when put to her. She comes into the room in an extremely demonstrative manner, stamping her feet on the

ground, occasionally striking her breast, or otherwise purposefully wringing her hands and moving her arms. She occasionally claps her hands. She has a good deal of tremor. When asked why she does all these things she gives no answer, but only demonstrates the more. Her functions are otherwise normal. No history of epilepsy in the family. Patient is brought to the hospital by her sister, who is an intelligent, sensible girl. By insisting on control of her demonstrations I was able to do a good deal towards improvement of the hysterical state. Until the following June she was given ignatia 12 and 30, and belladonna at night, with the result that the fits were much reduced in frequency and severity, and the mental state improved; whereas formerly she was useless at home, and had to have someone to look after her, she would now busy herself in washing and dusting. After some months from the beginning of her attendance I got her to talk a little, and found that she was the victim of a visual illusion at night, which she called up at will, as she said "she liked to see it." It was that of a vision of her dead mother in her coffin. I gave cannabis indica 3x. alone from July until December, pursuing a resolute moral treatment through her sister. Improvement in mental state appeared to be concurrent with a reduction in frequency and severity of the fits. She had no strong convulsions at this time. She was, however, liable to lapse mentally. After December, 1900, she received hyoscyamus for a few months, then cannabis indica again, and afterwards hyoscyamus and ignatia. She was seen only a few times last year, and once this. The last report was that there were few fits, but more dulness and depression than formerly. On the question whether the fits were really epileptic I may say they were. She had one in the out-patient hall, the character of which I was able personally to verify.

A remark on this case suggests itself. Had this patient been able to be treated in an asylum for the insane under homœopathic treatment, she might have made a much better recovery than she did.

*Case 15.—Petit mal.* E. M., aged 24, female, no occupation, suffered four to five years. Treated at Great Northern Hospital and Hitchin Infirmary. The supposed cause was anæmia for two years. She has twenty to thirty attacks every day, pallor, flushing, loss of consciousness lasting one to two seconds. She had four attacks lately, in which she fell down and was convulsed. I put her on valerianate of zinc 3x. with an immediate effect on



the attacks. The next report was she had only had one in fourteen days. On August 24 the report was, she had been having one to three a day, and going two to three days without. She did not appear again.

*Case 16.*—F. K., aged 22, female, came on December 6, 1900. Had seizures first at 13. They recurred but seldom until the onset of menstruation, since which they have been once a month. She has "screwing out" before the convulsion actually begins. Menstruation is regular without pain. Leucorrhœa in the interval. She received pulsatilla 30 until February 4, 1901, and afterwards with that protoxalate of iron. The attacks were reduced in frequency. They occurred as follows: February 4, March 13, May 5 (a very slight one), June 21, October 26. In 1902 in March, April, July, and August. This patient is still under treatment. She has been having the attacks at about the same interval.

*Case 17.*—E. D., aged 32, single, dressmaker, came in January, 1901. Had suffered three years. The first recurred after two years, then three months. Lately two major attacks in a week. They occur in the night. Is always overworked. Suffers from frontal headache, extending down the back. Is subject to chilblains. She was put on bell. at night, and sulphur in the day. Next time she came she was suffering from partial aphonia. There had been no attack. She received ignatia, causticum, verbasum, at intervals in the daytime. Bell. at night. A fit occurred on March 29. There was no other until May 12 the following year, then again on June 30, August 19, November 4 (in the day). She now received sepia in the day, bell. at night. An attack again on November 15 (ignatia again), but not afterwards until the following February. This patient is still under treatment, with recurrence about the same interval.

*Case 18.*—This case I published in the *Monthly Homœopathic Review* about three years ago.

T. H., aged 30, male. History of malarial fever and dysentery in Africa. Had his first fit in June, 1900, and ten since, occurring in groups, in January, May, September, and December. The attack is of the Jacksonian type, but, there being no monoplegia, and that the centre of disturbance could be localised in the Rolandic area, I concluded the case to be of constitutional rather than local origin, probably the result of toxæmia. An attack is described as follows: The little and ring fingers become contracted, then the hand, forearm, and arm; the head is bent to



the right, the patient loses consciousness and becomes generally convulsed. The attack lasts three to five minutes. He wakes up well in ten minutes. I gave *cicuta* 3. He had not had a recurrence by May 30, and I had a similar report at the end of the year.

I consider this last patient affords an illustration typical of the indications for *cicuta*, convulsions of local origin leading to general convulsions. Of course, in this case the patient may gradually have got rid of his toxæmia through residence in this country, but, even so, recurrence of the fits was likely, and prevention may partly be attributed to the *cicuta*.

*Case 19.*—H. R., aged 25, came on April 25, 1901, and is still under treatment. Duration of the attacks ten years. Is reported to have had double cataract as a little child, for which he was operated upon at 9 years of age, and then sent to school. At 14 he began to have "faints" and major attacks a few months later, both of which at the time of his visit recurred with an irregular periodicity. For example, he had several minor attacks every day. The major attacks occur once in one or two months, and then several within a day or two. The patient may be described as a typical example of the confirmed epileptic. He has no recollection of the occurrence of his fits. Has not been engaged in any occupation. Takes some interest in politics and social life. His response in speech is delayed, and mental action seems slow. He is irritable in manner, self-conscious, inclined to be voracious in appetite, is constipated, and has a high palatine arch. On his second visit he had one of his minor attacks in my presence. He became suddenly unresponsive to stimulus, uncommunicative, restless and distressed, also semi-convulsed. It appeared as if a major fit was trying to come on, and he was trying to get away from it. The attack lasted thirty seconds. He resumed his ordinary manner and conversation without knowing what had happened. This was, indeed, a formidable case to undertake, and with little prospect of improvement. However, I put him on *silic.* 30 in the daytime and a dose of *belladonna* at night, and the following is a condensed report of his case since. He has attended nearly regularly once a month.

For the first four attendances he had four major attacks in five weeks, and four minor in the day, six major in four weeks, two to three minor in the day, five major in four weeks, one to two minor in the day, eight major in four weeks, only four minor attacks all told. The report in August says he is much

improved in health. Has been having offensive perspiration of feet lately. Continue. The next account can be given from October until the following April. Silic. 12 was given in November instead of 30. The belladonna at night was not continued uninterruptedly, for reason not stated. Four major attacks in four weeks, one minor only; nine major, no minor; seven major, no minor; eight major, two very slight minor; seven major, no minor; eight major; eleven major, six of which occurred in the night; six major, all in the night, one in the day; six major, all in the night. Thus, up to April, 1903, the frequency of the major attacks tended to increase, but the minor ceased. It was rare for him now to have a fit in the day, a very great advantage, the major attacks occurring in the night. Moreover, the man's general condition had much improved. He is less irritable and self-conscious, answers questions more promptly and intelligently, takes more interest in life. From August, 1903, the number and frequency of the major attacks began to diminish. At this point he had sulphur 30 once for a month. In January, 1904, the report was no single attack for a month, then eleven very quickly, all in the night. February, three major; March, seven major in night, two in day; April, nine major, one in the day; May, eight major. At this point the medicine was changed to zincum 30 in day, and cham. at night, which has been continued up to the present. The patient had become rather slower in his ideas, but more voluble and irritable. June, one major attack only in the month; July, eight major; August, one only; September, eight major; October, one only, and so on up to the present time. Very rarely he has an attack in the day, and no minor attack at any time.

*Case 20* is another male, aged 14, who came in January, 1903, and attended until April, 1904, with attacks occurring every fourteen days, which appeared to be controlled by zincum 3. The last note says: No attack for several months.

*Case 21* is the case of a lad in whom the treatment appeared to be a complete failure.

W. G., aged 16, male, came in October, 1901. The duration was four years. He had been hard worked at school; had failed in an examination. He had been healthy as a baby. Twitching of the corners of his mouth had been noticed at 7 years of age. The second fit was three months after the first, and after that they gradually increased until the time of his attendance, when the recurrence was once in seven to ten days. He has an aura

of oppression in the chest, seeming to come from the stomach, as he says. He is restless and nervous, and has minor attacks consisting of twitchings and sometimes falling. He was given *nux vomica* in the day, *belladonna* at night. The indication for the *nux* was the kind of aura complained of, and the state of the boy's tongue, and other symptoms which seemed to point to this remedy. Attacks had recurred on October 23, November 8, 18, 25, December 3. He then had *nux vom.* 30 and *bell.* 3. Attacks again on December 9, 16; complained of tremor and nervousness. This state of matters went on for months, he receiving subsequently *silic.*, *sulphur*, and *calcareo carbonica*. In August, 1903, mental deterioration began to show itself. He thought something was haunting him. In November mania threatened, and he was obliged to be treated at home. He is now at the epileptic colony at Ewell.

*Case 22.*—This is a case in which the fits occurred later in life, the attacks being peculiar in some respects.

E. D., aged 45, female, had suffered from an abdominal tumour. Was an in-patient under Dr. Neatby. She came on April 11, 1902. For eight months she had suffered from transient loss of vision of the right eye, which would pass off if she pressed the right eyeball firmly to the right side. If she cannot brush the feeling away it extends to the left eye, and then she loses consciousness and has a major epileptic seizure. At her visits to the out-patient department one can frequently see her brush the feeling away from her eye and turn far to the right. After a major attack she feels she has been away a long time. She has been taking *cicuta*, *stramonium*, *œnanthe*, *anacardium ignatia*, but without apparent reduction in the number of attacks.

*Case 23.*—This is the case of a remarkable child sent me for an opinion and advice by Dr. Croucher, of Eastbourne.

M. L., aged 11, came in February, 1903. She had not attended school for nearly a year, and only had had two years of school life. Had suffered from tubercular disease of the joints, without suppuration, and meningitis seven years ago. Her first fit was two years ago, her second nine months ago, and there had been two since. She has an aura of a feeling in the right hand and warm sensation in the mouth. She is an excessively sensitive child, affectionate, except after a fit, when she has been very irritable. Is very fond of reading, especially stories with a plot, in which she gets extremely absorbed. She lives in these stories, and when not living in them is nervous, apprehensive, fidgety, and

hysterical. Sometimes she has fits of screaming. Her intellect is very acute; she can reason very intelligently, and any subject I introduced she was ready to give an opinion upon. I gave advice on reading, exercise, school, and general management of the child, and prescribed calc. phos. (seldom), with ignatia, stramonium, or belladonna, as the symptoms might direct. In September I saw her again, and the report was: Fits at intervals of three to one months until July, when she began to have them once a week. Mentally she appears to have improved. Before me she was less emotional. She had had some educational work since the previous visit. There were the remains of a chronic iritis in the right eye, and the eyes were very bloodshot under excitement. She talks very fast. Her parents complain of her being very irritable and perverse at home, quite unwilling to submit to parental control. She is an only child. The parents appear to apprehend the occurrence of the attacks very much. Dr. Croucher had been giving recently cyanide of zinc in the third trituration. I advised continuance of this and also the calc. phos. and ignatia. She had a fit on September 8, again on the 16th and 21st. At this point Dr. Croucher put her on bromide tabloids. She did not have another fit until October 27, again on November 16 and 20 and December 1. On December 26 there was another. She then received Peacock's bromides, a dose night and morning. There was not another fit until April 21 of this year, and none recorded since. I am indebted to Dr. Croucher for the recent notes.

*Case 24* is reported for the sake of a suggestion that some cases may be treated beneficially by means of nosodes. The result is, however, inconclusive, owing to the time a patient has been under treatment, and to another medicine being given at the beginning.

W. W., aged 37, carpenter, came on February 9 this year. He had suffered for three years, and had been treated at the Queen Square Hospital. His father had had meningitis when patient was a boy. He had been overworked and given way to drink before the fit. Had gonorrhoea before marriage, also syphilis. His first fit was early one morning in bed. He did not have another for a considerable time, but later they recurred once a month with dreadful feelings in between. Now he has a fit every morning and several bad feelings in the day. When eating, he has a hot, sinking sensation in the epigastrium, rising to the head. He begins to get tired, and has an illusion of smell as of burnt leaves. He may be able to rouse himself, and it goes off, if not, a fit ensues. He complains of pain over the right eye,

of vertigo and deafness. He hears a watch at nine inches on the right side and once inch on the left. He has droning in his ears. He received absinthum 3 t.d. On March 9 he had had one fit only. He had a symmetrical erythematous rash on both wrists. At Dr. Tyler's suggestion I ordered syphilinum 200 once a week, and continued the absinthum in the sixth dilution. March 23, two fits, rash gone, feels better. April 6, no fit, some bad sensations. 20th, no fits, some bad sensations, disagreeable, smell bad, bowels constipated, nux v. 3x, syphilinum as before. May 4, no fit, and none until the present month (June), when he had two. The question arises whether this patient still indulges in alcohol, but he declares not.

I have not read a case in which *œnanthe crocata* has been used as the chief remedy. I have had several, and two in which it appeared to have been of benefit. I have given the drug in doses of the mother tincture ranging from 3 to 8 minims, but I am inclined to think a dilution might serve as well, or perhaps better. At the risk of wearying you I could deal with other cases, but must pass to my concluding remarks suggesting the points in treatment and hygiene most worthy of discussion.

#### DISCUSSION OF HYGIENIC AND THERAPEUTIC METHODS.

(1) The cases I have read are very largely a record of failure to cure the malady for which the patient sought relief, and the question immediately arises, Was the treatment adopted the best that could have been adopted? More especially should this point be considered under the following questions: How far is one justified in withholding the bromide treatment? What further developments of the homœopathic plan are available? I do not think any canon or rule can be formulated on the first question. It must be left to individual discretion, and each case should be treated on the basis of its individual features. This view, of course, bars out a rule of the empirical adoption of the bromide treatment at the beginning of every case. Such might be justifiable, but I think only where the patient or friends have great cause to apprehend the occurrence of the fits. Fear does much harm on the

way to mental deterioration, and in many cases the occurrence of the fits does little harm to the patient, unless very frequent and after some years of recurrence. Where it is essential that a patient shall retain his or her employment, the bromide treatment may appear a necessity, but it must not be forgotten that permanent arrest takes place only in 10 per cent. of all cases, and even in these some mental deterioration ensues. Also from the homœopathic point of view, if the patient has once taken considerable doses of bromide, the medicine selected homœopathically will probably take longer and have its effect less easily. Then, for myself, I should like to ask, How can the homœopathic plan be more fully developed than it has been done in my cases? I am not sure I have always selected the best remedy. I have not been able to get away from a feeling of the necessity for immediate effort to control the attacks rather than to leave this as a secondary aim in view, and give one medicine alone with the possibility of ultimate cessation of the fits. Much out-patient work is done hurriedly and without a sufficient study of the *materia medica*, but of this I am certain, a review of my cases for the preparation of this paper will be of great use to me in the future. For the cases raise so many questions, the similar remedy, the single remedy, the dilution or potency, the repetition, the use of nosodes, and on all these points in the treatment of epilepsy I ask your opinion and indulgence for defects.

(2) A second point relates to the diet of epileptics. Abstinence from animal food has been recommended. I believe that in children suffering from these seizures abstinence from meat is essential, but in adults and confirmed cases it will make little or no difference, other morbid conditions calling for a vegetable or cereal diet being excluded.

(3) I plead for a more radical treatment after the first attack, chiefly in children, but also at all ages. I have seen several children in this hospital suffering from *petit mal* having a great many attacks of falling every day, and little could be done to stop the attacks. At the beginning would

it not have been well for these cases to have been kept in bed for some considerable time, say a few months, and again after a fit, and again before an anticipated recurrence? Care could be taken of muscular development by massage and electricity. It is the first fit which is the real illness, recurrences being simply recurrences of the same illness, with added tendency thereto.

(4) More attention is needed by parents and teachers to the mental development and training of children and to the early occurrence of twitchings and allied phenomena. This is a large subject, and progress seems slow, but the need for wider and more universally distributed knowledge is pressing in these days of high pressure and nervous strain.

(5) Lastly, that some attacks can be controlled when the aura is sufficiently pronounced is suggestive that the exercise of deliberative self-control ought to be an important factor in the prevention of the major attacks, provided always, of course, that other morbid states than developmental irregularities and an unstable mental equilibrium are excluded. This also is a wide subject, but deserves more attention than as yet it has received.

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Dr. BYRES MOIR, after thanking Dr. Goldsbrough for the clear way in which he had stated his subject, remarked that although the followers of the old school had written many papers on epilepsy and the use of bromide, he believed the present was the first occasion on which it had been discussed by a homœopath. Dr. Goldsbrough had asked how far homœopaths were justified in using bromides. He (Dr. Moir) was glad that matter had been brought forward, because, although he had never had any actual percentage of cures with bromide, he had seen several cases which had been cured by allopaths where homœopaths had failed. He had seen Sir William Gowers take charge of several cases which had been under homœopathic treatment and cure them. Homœopaths here and there also cured cases in which allopaths had failed, but they were rather isolated instances. Some very careful observations ought to be made in regard to what homœopaths were really doing in connection with epilepsy. He thought it must be left to the individual practitioner to decide whether he gave bromide or not. The point which had principally interested him was the



actual causation of the disease, on which a great deal had yet to be learned. He had been very much struck with the effect of the circulation in producing epilepsy, and would like to ask Dr. Goldsbrough's opinion on the two subjects of anæmia, and increased tension of the pulse. His attention was first of all drawn to the subject a long time ago by some cases of bradycardia. The first case was that of a gentleman, about fifty to sixty years of age, whose pulse used to drop down to 34, and even sometimes to 28, and he suffered from a form of epileptic seizure. He had seen him time after time, and could not separate his condition from true epilepsy. Whenever the heart got below a certain number of beats an attack came on. The next case in which he had attention drawn to the same thing was that of a child. In many children's cases, if the circulation was noticed, it would be found there was a point at which the attacks started. He had a personal experience with regard to the lowering of the circulation. He once had an attack of influenza from which he was recovering. He was very hard at work at the time. One evening when alone, on getting up, he suddenly fell against the wall, lost consciousness momentarily, and when he came to he found he had a regular clonic spasm going on. There was no doubt the condition of low circulation, following influenza, caused this state. He only mentioned this as an instance of one of the points where causation might begin, because there were many others, such as toxæmia and injury, which had to be considered. The author's remarks with regard to the care of the cases, especially when they were young, were most important. Once a child had *petit mal*, or a real attack of epilepsy, it ought to be treated as a serious case, and be taken in hand at once. Another point in connection with causation was the class of patient affected. Among the upper classes he saw very little epilepsy; it was only in hospital work that such cases were chiefly seen. He was therefore of opinion that the conditions of life had to be considered greatly in preventive measures. He had tried cuprum and plumbum with unsatisfactory results, and also *cenanthe* and *bufo*, but he obtained more benefit from *belladonna* than any other remedy.

Dr. BLACKLEY, after complimenting Dr. Goldsbrough upon his paper, regretted that the number of members present was not five or six times as large, because the subject ought to be of interest to everybody, whether in general practice or otherwise. The question of the use of bromides was very interesting, firstly, because a great many of the cases seen, whether in private or hospital practice, had already had bromides liberally administered,



and it needed a good deal of thought and determination to decide what was best for the patient. He was inclined to think it was easy to err on the side of allowing the patient to go on with the bromide. His feeling was very strongly in favour of dispensing with the use of bromide to the very greatest possible extent. Practitioners must not forget that bromide was not only a drug, but a poison, and that its continued use in the long run injured the mental powers. From time to time during the last twenty-five years he had seen a good many cases where bromide had been prescribed as a matter of course under allopathic advice, and where he had had to contend strongly with the patients, or their friends, as to its discontinuance. He had carried his point with considerable trouble, and in the very large majority of cases he had not seen any reason to regret it. Dr. Moir's remarks on the influence of circulation in the causation of epilepsy were of extreme interest. While Dr. Moir was speaking, he (Dr. Blackley) was reminded of a case he saw originally about twenty-five years ago, in consultation with their lamented friend Dr. Dudgeon. The lady, who was fifty-eight years of age, had been suffering for several years from heart attacks, tachycardia principally, with a good deal of surface flushing. That was all that took place at first. After those attacks, which mended under treatment, she quite suddenly developed *petit mal* of an unmistakable type, which continued for a very few months and afterwards developed into severe attacks. So long as she resided in London she was under his care for about fifteen years, and, having migrated to Hampstead, she had since been under the occasional supervision of Dr. Day. The patient was still living, and was now eighty-four years of age. His view of the case was that there was sclerosis, which had probably led to the tachycardia, and in all probability the sclerosis had invaded the cortex and brought on the attacks, first of *petit mal*, and then of *grand mal*. The *petit mal* attacks were extremely short, only lasting a few seconds. The patient lost the thread of what she was saying, stopped, and looked flushed and then pale, and almost cyanosed for a moment or two, and then went on with her conversation as if nothing had happened. Hydrocyanic acid, aconitine, and belladonna were beneficially used. According to recent reports, the attacks were now very much less frequent than previously; it appeared as if the old lady improved as she got older. There were also several interesting cases, which no doubt all present had seen from time to time, of epilepsy beginning during nephritis, some of which terminated fatally in the long run. He was now very occasionally seeing

a lady who began to have epileptiform attacks after nephritis brought on from scarlatina. The kidney condition appeared to have absolutely subsided, and the urine for years past had never contained any albumen. Unfortunately the attacks, which were nocturnal, went on; they were of the *grand mal* type, and did not seem to be influenced in the very slightest degree by medicines. Sometimes the patient would have three attacks in a month, and sometimes pass three or four months with only one attack; but they went on from one year's end to another, practically without any amelioration although the whole gamut of drugs—*cicuta*, *œnanthe*, *belladonna* and *plumbum*—had been tried in her case.

Dr. E. A. NEATBY said he was extremely interested to hear the author's pathological theories of the origin of epilepsy, because when he (the speaker) was house surgeon to Dr. Hughlings Jackson there was only one theory in existence, that of the explosive cortical lesions, the lack of inhibition being subsequently brought forward. The fact that Dr. Goldsbrough had been able to treat cases, with, at any rate, fair results from the point of view of general health or constitution, without a remedy which had any marked convulsive symptoms in its pathogenesis, was a great encouragement to persevere on strictly homœopathic lines. The question of the use or non-use of bromide had always presented itself to those who had been confronted with cases of epilepsy that had long been under the influence of bromide, as to whether it was justifiable or not to allow them, at any rate for a time, to have some fits in the hope of lessening the fits later, and improving the general health quickly. The points discussed by the previous speakers were important ones. In regard to the cure, it was more a question of the general condition, especially of the mental condition, co-existent with the improvement or the cure of fits. He thought it was very difficult for one individual, unless a specialist, to have enough cases to give an answer to such a question, and yet it was a question that demanded an answer very pertinently, because if the patient's nerve power, and especially his mental power, deteriorated with the diminution of the fits, in his opinion in most instances it was better to have more fits and to retain the mental power. It was very well known that a great many patients had deterioration of the mental power from epilepsy itself apart from the bromide, but it was his opinion that the downward progress of mental power was greatly accelerated by the use of bromide. Bromide alone would do it. When he had such cases he was always at pains to put before the patients that they would in all probability have to choose between fits and

the bromide, and the loss of mental power. He would like to ask the author if he had formed an opinion as to whether there was any relative proportion between the occurrence, first, of mental failure in *petit* or *grand mal*, and, secondly, the proportions of maniacal attacks in *petit* and *grand mal*. He would also like to know why Dr. Goldsbrough thought rest in the bed in early stages was desirable. He had always been taught, on the contrary, that a considerable amount of physical exercise, short of absolute fatigue, was one of the very best methods of treatment, both early and late. That was one of the strong points of Dr. Hughlings Jackson in his general cases, and also one that he had the opportunity of noticing very prominently, when he travelled for several months with a patient who walked twenty or more miles daily. One remedy mentioned by Dr. Goldsbrough was of use in children's cases, especially children where there was considerable mental excitement, passionate disposition, great resentment of control and liability to ebullitions of temper and extreme violence, namely, silica.

Dr. WYNNE THOMAS stated that he had obtained good results from the use of hydrocyanic acid. Dr. Madden and he had reported a case in the *Homœopathic Review*, of the previous month, of a patient on whom Dr. Burford had just operated. Within a week after the operation epileptic convulsions developed, although there was no history of epileptic fits previously. In that case hydrocyanic acid had a very marked effect, stopping the fits which had previously occurred many times a day. He remembered another case which he had under treatment from time to time, in which the same drug was most useful. Another patient who occasionally came to the hospital invariably got much better under *cicuta*. After taking the medicine for some weeks, the patient was quite free from the fits for some months, and then reappeared at the dispensary saying he wanted some more of the same medicine. The difficulty in such cases was in deciding what homœopathic medicine should be given, because in most cases there was so little indication. Fits were more or less alike in the great majority of cases, and the homœopathic indications very slight.

Dr. NICHOLSON (Bristol) had recently had a case of bradycardia where the pulse went down to about 35 a minute, and accompanied with convulsions. The convulsions were not very serious, but the other symptoms were very marked indeed, and went on for nearly a week. A week afterwards, the pulse returned to normal rather suddenly. He had never noticed that condition before, but

Dr. Moir's case had reminded him of it. He thought notice should be taken of it. It was very difficult to treat epilepsy for several reasons, one being that the practitioner did not see the patients long enough. Another was that they had generally had large doses of bromide continued for a long time, and only came to homœopaths when that treatment seemed a failure. He had a case lately of a lady about forty-five who had been given large doses of bromide for ten years, the only apparent effect upon her brain being that she had some loss of memory. Whether that was due to the bromide or to the attacks of epilepsy, it was difficult to say. When the attacks were very frequent he thought it was hardly right to immediately stop the bromide. He remembered one case which he had under treatment for a number of years where the epilepsy was associated with anæmia. For two different years the patient was taken to an asylum, and remained there under treatment for several months; and, except for the period during which he was in the asylum, during the rest of the time he was continually under treatment, and eventually entirely recovered. He could not put the curative effect down to any special drug, because in such cases the doctor was obliged to change the medicine according to the symptoms. He believed with Dr. Goldsbrough that the practitioner should treat the condition of the patient rather than the fits. In the case he mentioned the patient was extremely sensitive to the slightest indigestion; the least divergence from a rather strict form of diet, such as a glass of wine, smoking a cigarette, cheese for supper, or anything that was at all out of the strict routine of diet, would immediately bring on a nocturnal attack. He was inclined to think from his experience that if the patients under treatment were in view long enough the result was moderately successful. Whether homœopaths were more successful than others who adopted the bromide treatment he was not quite sure, but he was inclined to think they were.

Dr. MACNISH stated that within the last few years he had had two cases of young women who suffered from typical attacks of epilepsy. One was a patient at the hospital, and made no improvement whatever. Lately he had given these patients bromide of strontium, one grain morning and evening, and one of the patients was completely cured; she had not had an attack for two years, although she used to have one every week. The other patient now only had a fit at rare intervals, although she used to have them two or three times a day. Clinically, he always treated cases of epilepsy as due to circulatory disturbance, and not on the nerve

theory at all. He had found cocaine of value in two cases, and atropine also. Both of those medicines caused convulsive attacks similar to epilepsy. He also found atropine of value in amaurosis, which was a good deal connected with epilepsy. He agreed with the remarks of previous speakers as to not interfering too much to suppress the fits at the expense of the brain. The fits were very like the periodical bilious attacks people sometimes had; a good bilious attack and vomiting relieved the system very much. On the other hand, it was important in a mental sense to try and diminish the number of fits, because the patients and their friends and relatives usually judged the progress made by the number of the fits, and if the fits were increasing in number, it was difficult to convince them that the patient was improving. He would like to ask Dr. Goldsbrough whether he knew of a typical case of epilepsy where a person had only had one fit during life and seemed to have recovered from it.

Dr. LAMBERT stated that he had found artemesia very useful, especially in the *petit mal* condition, although he did not know whether it had much effect in *grand mal*. In most cases of epilepsy he found that more medicines than one were necessary, and it was very difficult to distinguish from the character of the attacks between the different medicines. He thought they were more likely to cure such a disease as epilepsy with silica, sulphur, and medicines of that kind, than with remedies which corresponded in their pathogenesis with the actual attack.

Dr. SPEIRS ALEXANDER (in the chair) thought Dr. Goldsbrough was to be congratulated, not only on the very interesting paper he had given, but on the discussion, which had elicited some very valuable opinions. The question of treatment was a very large and difficult one, one reason being that the attacks resembled each other so closely that it was difficult to differentiate between the medicines that were likely to be useful. If it were possible in each case to discover some peculiar and characteristic symptoms that were suggestive of a particular drug, there might be more hope of curing the cases than had been met with hitherto; because it was the experience of all that epilepsy, as far as its cure was concerned, was a reproach to homœopathy. If they were ever to succeed in curing it, he believed it would be along the good old lines of symptomatology, although the pathology of the disease was no doubt important from one point of view. He agreed with Dr. Goldsbrough in not prescribing for the fits, but in endeavouring to prescribe for the condition of the patient. With regard to the statistics of treatment, the system he had suggested would

prevent large statistics being obtained, because it would be impossible to treat 100 cases with one drug. In 100 cases, 100 drugs might have to be selected. It would therefore be very difficult to give any statistics as to the treatment of a definite number of cases by one drug or a series of drugs. Dr. Byres Moir's remarks with regard to pulse tension were exceedingly important, and were very well illustrated by a case he (Dr. Alexander) now had under his care, a lady of about sixty, who had been subject to fits for a number of years, and had been under bromide. The bromide had, to a certain extent, controlled the fits without curing her entirely. The patient came to him for something else, chiefly for eczema. He at once stopped the bromide and treated her for her general condition. The eczema very soon got well under graphites and a vegetarian diet. In passing he would like to say that again and again he had noticed, especially among American writers, that if any cure was expected in cases of epilepsy the patient ought to be put on a vegetarian diet. The patient he referred to had a slow pulse of high tension, and was exceedingly gouty, manifesting this state in various ways. After the eczema had got well and the patient had ceased taking bromides for some time, the fits recommenced. Taking her whole state into consideration, he determined to put her upon mercurius 1x three times a week, and at intervals he gave her nux vomica 12, which immediately began to control the fits, which had been getting pretty frequent, perhaps two or three a week. The patient now never had a fit more than once in four months. He believed that was due to the lowering of the pulse tension, to a certain extent through the treatment he adopted. He had no doubt leaving off the bromide was of great value to her, an experience which was borne out by many other patients.

Dr. GOLDSBROUGH, in reply, after thanking the Society for the kind way in which his paper had been received, asked: Did Dr. Moir suggest that both anæmia and high tension could act as a cause of epileptic fits? (Dr. MOIR: Yes.) If that were so—and he agreed that it might be—those conditions were not the real cause of the occurrence of the paroxysm but some inherent instability in the brain of the patients who were suffering from those things. That was the theory he wished to put forward. High tension might produce anæmia, *i.e.*, might hinder the blood supply through the brain, in the same way that an anæmic state hindered the blood supply, but why did not an epileptic paroxysm happen in every person who suffered? He did not wish to enter the region of argument, which was very difficult to establish, but only wished to be suggestive. He thought the primary condition in an



epileptic fit must consist in instability between the intellectual, or deliberative areas of the brain, and the motor areas. That was what he tried to suggest as the theory, although no theory was sufficient unless both the physiological side of thought and anatomical states were taken into account. Then there arose the intimate relationship of the blood supply; and there was no reason that he saw why, provided there was an instability of the equilibrium between the two great functions of the brain, an epileptic fit should not occur from the slightest disturbance of the blood supply. The equilibrium must be regarded as very fine, in fact they did not know on what a thread mental life was lived until it was disturbed in any way. In experience it seemed fairly constant, definite, and strong, but in the light of memory and the occurrence of an epileptic fit it was not. In the light of this view, both anæmia and high tension were secondary causes of an attack. Dr. Neatby raised the very important point as to the frequency of mental deterioration in the different classes of attack. Mental failure, he thought, tended to be greater in the major attacks, and also the occurrence of mania, except in some mild attacks consisting only of mania. He had a curious case recently of a little child who was suddenly taken with a maniacal attack in the room. He regarded this as an attack of epilepsy affecting the frontal region of the brain. The child was mad for a few minutes at a time. The mother brought her to the hospital for treatment. Frequency was an important factor in such cases. The more frequent the fits, the more likely was it that mental failure would follow, which raised the point as to bromides. Any person could bear an epileptic fit occurring once every three or four months without any harm, but when they occurred several times a day, or every two or three days, then it became a matter of grave consideration as to what the effect of the fits would be, and whether the effect of the fits or the bromide would be the worse for the patient. If one could reduce the attacks down by any means to once a month or once in two or three months, then it was possible to do without bromide, because the patient would never actually suffer from the fit, and the homœopath could go on with his treatment. The important point was to reduce the fits from that terrible rate of frequency at which they sometimes occurred down to a frequency which was safe for the life of the patient. He recommended rest in bed as a means towards the prevention of the recurrence of a first fit. He had read and heard of making the patient undergo tolerably severe muscular exercise as a preventive

of fits. He tried it in one case, and it answered up to a certain point, but not thoroughly. He thought a long rest in bed before allowing the patient to resume ordinary life might ensure that the brain equilibrium was restored. He thought the hospital had not done nearly as much yet for children as could be done by homœopathic means, and that the way was opening up for dealing with this disease, if it were treated seriously enough. The occurrence of a fit should be regarded as quite a serious event in a child's life. He was much interested in the case of Mr. Thomas's, published in the *Review*, and he regarded that sort of case as the indication for hydrocyanic acid. A case of the first fit, of the first *grand mal*, was the doctor's chance of doing good with hydrocyanic acid. He had not used hydrocyanic acid to his knowledge since the first case he mentioned in the paper, because the cases that came to the hospital were not recent enough. He thought those remarks also applied somewhat to absinthum and artemesia, which were indicated in early cases. He had tried bromide of strontium in a case of *petit mal* in the wards some years ago. The attack was nothing but a falling—the patient used to fall down and get up again. This was evidently an epileptic seizure, and bromide of strontium had no effect in the case. Dr. Watkins had used this drug in a private case, apparently of the Jacksonian type, which had been in the hospital and had apparently recovered. He had not looked into the pathogenesis of cocaine sufficiently to verify Dr. MacNish's point. Atropine produced convulsions, but in belladonna they had a better drug. It was possible for a person to have one fit and not another, such cases were on record. He believed they ought to put on record every case they had of every disease, and then, if statistics were to be any good, no one could take exception to the action.

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## CASES, SPECIMENS, &c., EXHIBITED AT VARIOUS MEETINGS.

### CASES.

#### *Empyema of the Ethmoidal and Frontal Air Sinuses.*<sup>1</sup>

The patient had been suffering for years with it, the symptoms being a spell, variable as to length, of intense frontal headache, followed by swelling and redness over left orbital arch at its inner

<sup>1</sup> Exhibited by Dr. C. W. HAYWARD, Liverpool Branch, May 11, 1905.



extremity, which discharged pus—this was the condition when the case was shown, marked relief to the headache having followed the setting in of the purulent discharge. There was no history of nasal catarrh or of unusual nasal discharges.

*Serous Pleural Effusion.*<sup>1</sup>

A patient, male, stableman, admitted to hospital on previous day, whose left chest proved on examination to be full of fluid. Had suffered comparatively little inconvenience beyond breathlessness, and there were neither pulse nor temperature rate.

*Muscle Hypertrophy (?)*.<sup>2</sup>

A man, aged 28, painter, suffered from a peculiar swelling of the left arm. Gave the following history : Eighteen months ago, he one day noticed, when stripped, that his left arm was swollen. He had had no pain, but was so alarmed at its size that he went to a doctor, who told him that a block had occurred in one of his veins, which was the cause of the swelling. He saw the doctor altogether only twice, and in about two weeks time the swelling had disappeared. The treatment, in addition to the usual bottle of medicine, consisted in occasional soda fomentations.

Nine weeks ago he again became aware that the arm was swollen. Again there was no pain, and the arm has remained swollen ever since.

The swelling appears confined to the muscular tissues ; there is no trace of œdema, but the muscles stand out in sharp outlines, rivalling Sandow's development. The pectoral and also the scapular muscles, particularly those forming the posterior axillary fold, were also hypertrophied.

The patient, a painter, uses his left arm but slightly compared to his right ; occasionally when doing ladder work he has to use the left to hold on by.

He indulges in no physical drill or outdoor sport of any description.

The patient is most positive that the swelling of eighteen months ago entirely disappeared, and he has kept daily measurements of the limb these last nine weeks, which show that the swelling has neither increased nor diminished during that time.

He has never been off work with it, and only suffers very occasionally with slight cramp in the fingers of the left hand ; apart from that there are no dysæsthesias.

<sup>1</sup> Exhibited by Dr. GORDON SMITH, Liverpool Branch, May 11, 1905.

<sup>2</sup> Exhibited by Dr. JAMES WATSON, Liverpool Branch, May 11, 1905.

Patient is, and has always been, a teetotaler and a non-smoker. He has suffered from rheumatic pains in hands and knees some years ago, pains < damp weather. He has no alternating strabismus. Never had syphilis nor gonorrhoea.

*Cerebellar Tumour.*<sup>1</sup>

J. S., aged 12. Admitted to the hospital some years ago with vomiting. Found to have ataxic gait, later, double optic neuritis, followed by atrophy of discs and vessels of fundus. Knee-jerks are increased. Never had headaches. Fits are frequent. Emotional; very backward at school. Tremor of arms.

*Treatment.*—Tuberculinum 30. Arsen. iod. 3.

*Interstitial Keratitis.*<sup>1</sup>

A. F., aged 7. Admitted when 1½ years old with congenital syphilis. Treatment, merc. v. 2x. Came again December 19, 1904, with interstitial keratitis, intense photophobia. Hutchinson's teeth. Intense injection of the conjunctivæ. Complete opacity of left cornea, partial in right.

*Treatment.*—Merc. cor. 2x. Atropine drops. Marked improvement at once on giving weekly doses of syphilinum 200.

Patient now cured, with perfect vision.

Dr. Alexander asked whether any other drug besides syphilinum was taken in this case, and how the syphilinum was continued, and under what circumstances it was prescribed in syphilitic cases.

Dr. Roberson Day said that in the first instance he prescribed merc. v. in the second decimal, and the child improved under the treatment. After a time he was led to give syphilinum, a remedy which he had been trying a great deal lately. In fact, he was giving it in all syphilitic cases as a matter of routine, and he was also using it in other cases. As soon as the child began to take it, the improvement was very marked indeed. The child was improving on the merc. v., but the improvement was much more rapid after the syphilinum. The latter was given once a week.

Dr. Madden asked whether Dr. Day had given the syphilinum under the 200.

Dr. Day replied that he had given the 30th, but he preferred the 200.

*Congenital Syphilis.*<sup>1</sup>

*Case 3.*—Younger brother of above, with congenital syphilis,

<sup>1</sup> Exhibited by Dr. ROBERSON DAY at the Clinical Evening, June 1, 1905.

and came with Erb's paralysis from injury at birth, and fractured clavicle.

*Treatment.*—Merc. v. 2x and 30, and syph. 200.

*Pseudo-hypertrophic Paralysis.*<sup>1</sup>

Male, aged 14. The third in a family of four boys; the two others having previously been exhibited before the Society.

Dr. Goldsbrough, in answer to Dr. Byres Moir, said that he had been watching this family very carefully. He had had them under observation for about seven years. The two other boys affected were older than the present patient. They had steadily gone on in the ordinary natural course of the disease, uninfluenced by treatment. The fourth boy unaffected was in age between the other two and the present one. The boy that was not affected came between the one 20 years of age, who was treated seven years ago, and the present one, but it was a rather remarkable thing that he was not affected with the disease. The disease, as a rule, only occurred in boys. In this family there were no girls, and, as it occurred, it naturally put an end to the family. There was some deep degenerative process going on, and the association of it with the males of a family and not with the females was a remarkable thing and worthy of elucidation.

As a rule, the patients died from want of nutrition. Their muscles became so wasted that the patients could not get up off the floor. The eldest of the four boys crawled about the room on his hands and knees. He had had fluctuations in his history, and had sometimes been very weak and not able to get about at all. Sometimes he recovered partially and was able to crawl.

*Jacksonian Epilepsy with Hemiplegia.*<sup>1</sup>

Male, aged 23. Relieved by trephining in the forearm area. Operation by Mr. Dudley Wright. A cyst in the cerebrum, probably secondary to syphilis, evacuated. No fits since the operation. Hemiplegia improved.

Dr. Byres Moir wished to know whether there was a syphilitic origin in this case?

Dr. Goldsbrough replied in the affirmative. It was three months after the onset of the disease that the hemiplegic seizure took place.

Mr. Dudley Wright said that the brain tissue was, to a certain extent, sunken. There was the condition found called yellow

<sup>1</sup> Exhibited by Dr. GOLDSBROUGH, June 1, 1905.

softening. His diagnosis was that of syphilitic thrombosis. The cystic degeneration had since developed. There was no thickening of the wall left.

### *Lymphatic Leukæmia.*<sup>1</sup>

The patient, a man, aged 62, a printer by occupation, was admitted to the hospital three months ago with swelling of lymphatic glands, inguinal axillary and cervical, which had been in existence six months, gradually increasing. Soon after admission the blood was found to contain 19,000 leucocytes per cb. mm., of which 87 per cent. were large and small lymphocytes. Two months later the leucocytes numbered 73,000 per cb. mm., of which the large and small lymphocytes comprised 79 per cent., and neutrophile myelocytes were present to the extent of 6 per cent. He was at first placed under Woodhall Spa water, but at the end of three weeks this was given up. He is now taking one-grain doses of potassium iodide and is doing fairly well, except that the symptoms point to implication of mediastinal and mesenteric glands.

Dr. Blackley, in reply to a question relating to the condition of the leucocytes, said that, as a rule, the leucocytes were not increased, and the relative proportions of the various forms were undisturbed. This case was remarkable because the leucocytes were not only very largely increased, but 79 per cent. of these were of the lymphatic variety. The ordinary polynuclear leucocytes were very few indeed. The mass in the abdomen was not very easy to examine thoroughly in a few minutes, but it was thoroughly examined a few days ago. The abdominal walls were very lax, and there was no difficulty whatever in feeling that, whatever the mass was, it went right back to the spinal column, and was rather firmly fixed to the spine. The patient had so far not responded very well to the medicines prescribed. Woodhall Spa water, which answered so well in ordinary scrofula, had had no beneficial effect on this patient; indeed, he was not very certain that it did not upset him in various ways. He (Dr. Blackley) was sorry to say that the patient had lost flesh pretty steadily since his admission. He was going to put the man under treatment with the X-rays as a therapeutic measure. The microscopic slide showed the white cells as consisting almost entirely of large and small lymphocytes. There were now a few

<sup>1</sup> Exhibited by Dr. BLACKLEY, June 1, 1905.

myelocytes, and it looked as if a little splenic element was beginning to enter into play.

### *Still's Disease.*<sup>1</sup>

Still's disease, or chronic rheumatic arthritis, with enlargement of the axillary glands, in a child.

Dr. Johnstone said that this was an extremely interesting case. The disease evidently combined rheumatism, rickets, and tuberculosis.

Dr. Blackley asked Dr. Byres Moir as to the pathology of the case. The symptoms, he took it, were practically what they could see by looking at the surface. Was there anything lying behind the physical symptoms as they appeared?

Dr. Byres Moir said that there was not. The question of the pathology had not been definitely settled yet. Under the X-rays the case showed the bone unchanged. The tissues round the joint were affected. It was said that they were waiting for a name for the disease. When he got the child into the hospital he put him on silica. There was no pain, but wasting was taking place in the muscles between the joints, and he thought himself that tuberculin was not so much indicated as iodine.

### *Deflected Septum Narium.*<sup>2</sup>

Operated on at the London Homœopathic Hospital. The case mentioned in Dr. Alexander's paper on the subject (p. 379.).

## SPECIMENS.

### *Dermoid Hair.*<sup>1</sup>

A specimen of hair from a dermoid in coccygeal region, simulating ordinary abscess.

### *Renal Calculus.*<sup>3</sup>

An oxalate renal calculus, extracted from the left side of a "horseshoe" kidney.

### *Ovarian Tumour.*<sup>4</sup>

A malignant ovarian tumour removed by operation. Death.

<sup>1</sup> Exhibited by Dr. BYRES MOIR, June 1, 1905.

<sup>2</sup> Exhibited by Dr. SPIERS ALEXANDER, June 1, 1905.

<sup>3</sup> Exhibited by Mr. A. A. BEALE, November 3, 1904.

<sup>4</sup> Exhibited by Dr. E. A. NEATBY, November 3, 1904.

*Uterine Fibromyoma.<sup>1</sup>*

Intramural uterine fibromyoma, removed by myomectomy. Recovery.

*Uterine Fibromyoma.<sup>1</sup>*

A uterine fibromyoma, removed by hysterectomy on account of hæmorrhage and cardiac weakness. Recovery.

*Uterine Fibromyoma.<sup>1</sup>*

A uterine fibromyoma, showing subperitoneal pedunculated nodules ("hard fibroids") and intramural degenerating myomata ("soft fibroids"); removed for pressure symptoms. Recovery.

Microscopic sections of last-named, showing structure of "hard" and "soft" portions.

*Perforated Gastric Ulcer.<sup>2</sup>*

In servant 22 years of age. Perforation and death two hours after admission into Phillips' Hospital, Bromley. An ulcer in anterior surface and also in posterior surface.

*Ovarian Cyst.<sup>3</sup>*

A glandular carcinomatous cyst of the ovary removed by operation. Recovery. Microscopic section of the same with unusual features.

*Uterine Myoma.<sup>4</sup>*

Myoma of uterus, removed by hysterectomy. Recovery.

*Cancer of Pancreas.<sup>5</sup>*

Microscopic section of malignant disease of the head of the pancreas.

*Specimen and Section of Rectum.<sup>6</sup>*

Macroscopic and microscopic specimens of rectum obtained *post mortem* from a case of ulcerative colitis.

<sup>1</sup> Exhibited by Dr. E. A. NEATBY, November 3, 1904.

<sup>2</sup> Exhibited by Dr. H. WYNNE THOMAS, December 1, 1904.

<sup>3</sup> Exhibited by Dr. MOLSON and Dr. E. A. NEATBY, December 1, 1904.

<sup>4</sup> Exhibited by Mr. A. A. BEALE, January 12, 1905.

<sup>5</sup> Exhibited by Mr. F. A. WATKINS, January 12, 1905.

<sup>6</sup> Exhibited by Dr. BYRES MOIR and Mr. F. A. WATKINS, February 2, 1905.

*Uterine Myoma.*<sup>1</sup>

A uterine myoma, showing subperitoneal, submucous and intramural growths and calcareous degeneration. The tumour was removed for threatening pelvic impaction. Recovery.

*Extrauterine Gestation.*<sup>2</sup>

Double extrauterine gestation, consisting of tubal mole in the right Fallopian tube, and tubal gestation in the ruptured left Fallopian tube: with both foetuses. Operation. Recovery.

*Ovarian Cyst.*<sup>2</sup>

Ovarian cyst from the left ovary, following six years after removal of a similar ovarian cyst on the right side. Operation. Recovery.

*Carcinoma Uteri.*<sup>2</sup>

Carcinoma cervicis uteri, removed by vaginal hysterectomy. Operation. Recovery.

*Carcinoma Uteri.*<sup>2</sup>

Carcinoma uteri, removed by vaginal hysterectomy. Operation. Convalescence.

*Uterine Myoma.*<sup>2</sup>

Myoma uteri, with calcareous degeneration of a part. Operation. Recovery.

*Uterine Myoma.*<sup>2</sup>

Large myoma uteri, weighing 13 pounds, growing a year after the menopause. Operation. Recovery.

*Uterine Myoma.*<sup>2</sup>

Myoma uteri, removed on account of recurrent hæmorrhage and cardiac symptoms. Operation. Recovery.

*Myoma Uteri.*<sup>2</sup>

Myoma uteri, removed because of intractable hæmorrhage, with attending cardiac dilatation. Operation. Recovery.

*Epithelioma Labia.*<sup>2</sup>

Epithelioma of right and left labia vulvæ and clitoris. Complete excision.

<sup>1</sup> Exhibited by Drs. SPENCER COX and E. A. NEATBY, February 2, 1905.

<sup>2</sup> Exhibited by Dr. BURFORD, March 2, 1905.

*Cervical Cystoma.<sup>1</sup>*

A primary ovarian cystoma removed by operation. Recovery.

A microscopic section of above, showing epithelioid-carcinoma structure. The tumour was of rapid growth in a woman of 45. It distended the left broad ligament and filled the true pelvis and lower half of abdomen; it contained 10 pints of fluid.

The specimen shows warty growths, partly innocent, partly carcinomatous; undergoing colloid changes. It is a remarkably vascular growth.

*Pyosalpinx.<sup>2</sup>*

A pyosalpinx, with section of uterus constituting part of the abscess. The patient was under observation for twelve months with chronic pelvic peritonitis. She had a sudden access of fever necessitating active treatment. The blood appearances, as examined by Mr. Watkins, indicated gonorrhœa.

*Cervical Fibroid.<sup>2</sup>*

A cervical fibroid, burrowing in the connective tissue of the pelvis; enucleation. The patient suffered from persistent dysuria, but no hæmorrhage of consequence. The patient's sister had already been operated on for a similar condition.

*Large Broad Ligament Fibroid.<sup>2</sup>*

This patient was unmarried and suffering mainly from distress due to bulk of growth. No cardiac symptoms or considerable hæmorrhage. Enucleation and recovery.

*Large Uterine Fibroid.<sup>2</sup>*

Drenching hæmorrhages, profound anæmia, cardiac multiple bruits. Hysterectomy; transfusion to 2½ pints during operation. Convalescence for one week; incision then found to be in no wise united. Stitches removed; contiguous intestines taken out and washed; contiguous wound surfaces thoroughly disinfected; incision sutured with silkworm gut; union satisfactory. Patient now suffering from acute thrombosis. Hæmoglobin 20 per cent.

<sup>1</sup> Exhibited by Dr. E. A. NEATBY and Mr. F. A. WATKINS.

<sup>2</sup> Exhibited by Dr. BURFORD, June 1, 1905.



*Renal Calculus, with Skiagram.*<sup>1</sup>

A branching renal calculus, coated with oxalate of lime crystals, removed from the right kidney of a man, aged 50. The patient had passed a small uric acid calculus, *per urethram*, some six or eight years previously. Prior to that he had some lumbar pain and a trace of hæmaturia. For three or four years he had been passing constantly large quantities of uric acid and oxalate of lime crystals in the urine, together with red and white cells, hyaline casts, and a trace of albumen. He had had no pain or hæmaturia. The skiagram, by Mr. Coldwell, showed stone *in situ* before operation.

*A Luys' Segregator.*<sup>1</sup>

A Luys' Segregator, for drawing off the urine from each kidney separately.

*A Cystoscope.*<sup>2</sup>

A modified Nitze-Albarran cystoscope, for catheterisation of the ureters. A "dummy" for demonstrating the use of the cystoscope.

*Senile Uterus.*<sup>2</sup>

A senile uterus, showing endometritic changes. The main bulk of the specimen consists of a number of subperitoneal fibromyomata. The patient was known to have a pelvic tumour, but she had latterly developed an offensive blood-stained discharge. For this reason an exploratory dilatation was being performed, when it was discovered that the dilator had perforated the uterine wall. The perforation is shown in the specimen by a glass rod. On account of the septic nature of the uterine discharge the uterus was at once removed by abdominal retroperitoneal hysterectomy. The patient is convalescing uneventfully.

*Carcinoma Uteri.*<sup>2</sup>

A uterus removed from a single woman, aged 46, by vaginal hysterectomy. The operation was performed with the aid of a free lateral perineal incision, on account of the extreme narrowness of the vagina. The specimen shows the body of the uterus to be very completely infiltrated with a carcinoma which the microscope shows to be of a glandular type. The patient was extremely blanched by hæmorrhages and had a cachectic hue. There were

<sup>1</sup> Exhibited by Mr. DUDLEY WRIGHT, June 1, 1905.

<sup>2</sup> Exhibited by Dr. E. A. NEATBY, June 1, 1905.

hæmic bruits at all the valves. The broad ligaments were secured, partly by ligature, but mainly by forceps, which were removed in thirty-six hours. Convalescence satisfactory.

*Myosarcoma Uteri and Water-colour Drawing.*<sup>1</sup>

Uterine myosarcoma removed *post mortem* from a young subject. The tumour had grown rapidly and was greatly embarrassing the patient's locomotion and respiration. An exploratory examination was abandoned on account of the universal adhesion and the hæmorrhage. From this the patient made a good recovery. She died some time after having left the hospital. At the autopsy, performed by Dr. Hey, an abscess between the tumour and adherent bowel was found. The tumour is of an extremely lobulated character, and the posterior surface shows immense vessels penetrating between the lobes. The growth is undergoing hyaline and necrotic changes.

Water-colour drawing, by Miss Mabel Green, showing the original colour of the cut surfaces, and some remarkable areas of yellow degeneration.

*Slide showing Phagocytosis.*<sup>2</sup>

In this slide the white cells were seen to have taken up *Staphylococcus albus*. The blood, with an emulsion of staphylococcus, had been put into an incubator for a fixed time, and a smear prepared. Twenty white cells were examined and the number of cocci taken up counted, and the phagocytic power of the blood estimated.

*Aneurism of Aortic Arch.*<sup>3</sup>

This aneurism had ruptured into the pleura.

*Myoma Uteri.*<sup>4</sup>

A soft myoma uteri removed by hysterectomy. Recovery. Large ovary from same case showing lutein hæmatoma, with microscopic slide showing lutein cells.

<sup>1</sup> Exhibited by Dr. E. A. NEATBY, June 1, 1905.

<sup>2</sup> Exhibited by Mr. DUDLEY WRIGHT, June 1, 1905.

<sup>3</sup> Exhibited by Dr. BYRES MOIR, June 28, 1905.

<sup>4</sup> Exhibited by Dr. E. A. NEATBY, June 28, 1905.

BRITISH HOMŒOPATHIC SOCIETY—SESSION  
1904-1905.

## REPORT OF COUNCIL.

At the opening meeting of the Session the painful news of the death of Dr. Dudgeon was announced, and the meeting was adjourned as a mark of respect to the deceased.

It was decided to undertake the formation of a Dudgeon Memorial, and for this purpose subscriptions to the amount of ninety-four guineas have been collected. The oil portrait of our venerable colleague, which has been placed in the Board Room of the London Homœopathic Hospital, forms the chief feature of this Memorial. In addition, a carbon enlargement of an excellent likeness of Dr. Dudgeon has been executed, and a cabinet platinotype for distribution among the contributors.

An interesting event of the Session was the celebration of the Ter-jubilee of Hahnemann by a Festival Dinner at the Hotel Cecil, an account of which is preserved in the Journal of the Society.

Owing to the adjournment of the first meeting the Presidential Address was not delivered until the December meeting, under the auspices of the Surgical and Gynæcological Section. Dr. Johnstone chose for his subject "Abdominal Palpation during Pregnancy and Labour." In addition to this, fourteen papers were read and discussed during the Session, and the ninth meeting was signalled by a "Clinical Evening."

A new departure has been made by the Council, in the formation of a Magazine Club, connected with the Library, by which some of the American journals are circulated by post among members.

Several new books have been added to the Library, besides a number of old books from the library of the late Dr. Dudgeon, which were not already found on its shelves.

Two new Fellows, Mr. Watkins and Mr. Wilkinson, have recently been elected.

The Society has lost three members by death and two by resignation; one new member only has been added to its ranks.

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THE BRITISH HOMŒOPATHIC SOCIETY.

Dr. BALANCE SHEET—SESSION 1904-1905. Cr.

RECEIPTS.		EXPENDITURE.	
	£ s. d.		£ s. d.
To Balance in Hand ..	95 13 4	By Rent ..	25 0 0
„ Dividends on Consols ..	4 19 4	„ Honorarium to Editor ..	10 10 0
„ Subscriptions ..	189 0 0	„ Printing, less advertising ..	165 2 1
„ Sale of Publications ..	11 18 9	„ Library ..	12 2 3
„ Half cost of Plates ..	2 18 6	„ Postage and Stationery ..	9 11 1
„ Cash in Hand.. ..	6 6 0	„ Refreshments ..	5 10 0
		„ Petty Cash ..	12 12 0
		„ Balance ..	240 7 5
			70 8 6
	£310 15 11		£310 15 11

H. E. DEANE, Auditor.

June 28, 1905.

J. G. BLACKLEY, Treasurer.

## THE DUDGEON MEMORIAL.

At the meeting of the Society on June 29 the report of the Council was presented, and contained a reference to the Dudgeon Memorial. A sum of ninety-four guineas had been raised, which had been expended mainly on an oil painting of Dr. Dudgeon, by Mr. Philip Stretton, R.I., his son-in-law. In addition a carbon enlargement of an excellent likeness of Dr. Dudgeon had been executed, and a cabinet platinotype prepared for distribution among the contributors to the memorial. A reproduction of this likeness appears with this number of the Journal. After this statement had been made by the Secretary at the meeting, Dr. Blackley proceeded to an unveiling of the oil painting, which ceremony he prefaced by the following remarks:—

GENTLEMEN,—I feel deeply the honour you have done me in selecting me to unveil the portrait of our departed colleague, one whom we all loved and revered, and upon whose like we shall not soon look again. After the symposium of last October it is not very easy to say anything new of Dudgeon, but I would like to bring into special prominence the debt we owe him for his literary labours in the cause of homœopathy. Dudgeon's period of foreign study, and the thorough grasp he had of anything he undertook, soon made him perfectly at home in both the French and German languages, and, as you all know, it was his study of German medical literature that led him to Hahnemann and homœopathy. He was not slow to give the world the benefit of the knowledge so gained.

In 1846, at the age of 26, he joined the editorial staff of the *British Journal of Homœopathy*, and only laid down his pen when the publication of the journal came to an end in 1884, he being then 64 years of age. What a mine of wealth is contained in the forty-two volumes of the journal, only those who are the fortunate possessors of a complete series can thoroughly realise. Next, in 1847 appeared a pamphlet on the "Homœopathic Treatment of Cholera"; Hahnemann's "Organon of Medicine" in English, in 1849; "Pathogenetic Cyclopædia," part i., in 1850; "Hahnemann, a Biographical Sketch," in 1852; "Lectures on the Theory and Practice of Homœopathy," a volume of 565 pp., and of which I hope we shall one day see a reprint, in 1854; Hahnemann's "Lesser Writings," in 1857; the volume on

"Aconite," in the Hahnemann Publishing Society's *Materia Medica*, in 1858; Hahnemann's "*Materia Medica Pura*," edited by Dudgeon and Hughes, in 1880. "Hahnemann, the Founder of Scientific Therapeutics," was the Hahnemannian Oration of 1882, and appeared in that year; Hahnemann's "*Therapeutic Hints*" appeared in 1894; and his "*Defence of the Organon*," in 1896. The "*Cyclopædia of Drug Pathogenesis*," with which you are all familiar, so far as excerpts from German literature are concerned, owes everything to Dudgeon.

In matters controversial many of the ablest letters which appeared in the pages of the daily press during the "*Odium Medicum*" episode came from the pen of our gifted colleague, and did the cause of homœopathy and homœopaths lasting service.

Dudgeon also wrote a highly original treatise "*On the Mechanism of the Human Eye*," and as the result of his studies in this little-known department of physiology, invented a pair of spectacles to be worn under water which enabled the wearer to see objects on the bottom as plainly as without them he could see in the air.

Dudgeon was Secretary of the Society in 1848, and was the first to be elected to the presidential chair after the death of the previously perpetual president, the late Dr. Quin. As a member we all know how regular he was in his attendance to the very end of his life, and how ready he always was to take part in a discussion and to contribute something to the stock of our knowledge.

If I were asked to sum up in a few words the characteristics of Dudgeon which most impressed me, I would say: (1) his transparent honesty; (2) his thoroughness; (3) his indomitable industry; and (4) his breezy good temper.

After the portrait was unveiled, Dr. MADDEN rose and said: I consider it a great honour and privilege to have been selected as one of those chosen to represent our Society this evening in showing our appreciation of, and reverence for, the memory of Dr. Dudgeon, whose memorial portrait has just been unveiled. In one sense my task is an easy one, for our friend has been so recently taken from us, and kept up his regular attendance at our meetings right on to the end of his life, that all I have to do is to remind you of some of the excellent good qualities in a man you all knew as well as I did, and many of you from being nearer neighbours knew him even more intimately than I had the possibility of doing. But in another sense it is a task of great difficulty, for how can the pigmy do justice to the giant, and how

is it possible for a one- or two-sided man like myself to do anything like justice to the character of a man who was like a well-cut diamond with many facets, each of which could sparkle with almost equal brilliancy if held in the right light?

And herein, viz., in his manysidedness, lay one of Dudgeon's greatest charms, for it gave him a power of intelligent sympathy with almost any one in whose company he chanced to be; did he find himself at a scientific society, at a political debate, at a literary gathering, or in a company of sportsmen, he could hold his own and add to the general fund of knowledge, interest, or amusement, better than most men, while as a speaker, whether on the platform, or after dinner, or as a *raconteur* round the table, he had few equals. Being a Scotchman, it is hardly necessary to add that he had a full share of humour both appreciative and productive, and this I say advisedly, for we who are the happy possessors of Celtic blood know that, if any, it is the Anglian partner in the British brotherhood has been given a lesser share in the seeing and making of true fun. What he was as a writer, whether didactic or controversial, you have already heard, and need not be again repeated.

Old age alone is by no means necessarily a proof of a good or useful life; but when we can say, as we can of our friend Dr. Dudgeon, that he lived for well nigh sixty years in the forefront of the rank of our cult, that he never flagged either in his work or his interest in it, and that he remained one of our most prominent leaders all this time, even up to the last, and was one of our hardest and most successful workers, that, indeed, is a record of which we may well be proud and that fully entitles him to all our honour, reverence and love, and we may well keep him in memory as having lived a life which was a splendid example of vitality and enthusiasm, and one which we may all try to copy.

#### LIST OF SUBSCRIBERS TO THE DUDGEON MEMORIAL.

						£	s.	d.
Alexander, Dr. Spiers	..	..	..	..	..	2	2	0
Ashton, Dr.	..	..	..	..	..	1	1	0
Blackley, Dr.	..	..	..	..	..	2	2	0
Brown, Dr. Dyce	..	..	..	..	..	2	2	0
Bryce, Dr. W.	..	..	..	..	..	2	2	0
Burford, Dr.	..	..	..	..	..	2	2	0
Burwood, Dr.	..	..	..	..	..	2	2	0
Cash, Dr.	..	..	..	..	..	2	2	0
Chalmers, Dr.	..	..	..	..	..	2	2	0
Chapman, Dr.	..	..	..	..	..	0	10	6

						£	s.	d.
Clifton, Dr. A. C.	..	..	..	..	..	1	1	0
Clifton, Dr. Geo. ..	..	..	..	..	..	1	1	0
Compston, Dr. ..	..	..	..	..	..	0	10	6
Cooper, Dr. M. Le H.	..	..	..	..	..	1	1	0
Cox, Dr. Spencer ..	..	..	..	..	..	1	1	0
Cronin, Dr. ..	..	..	..	..	..	2	2	0
Croucher, Dr. A. H.	..	..	..	..	..	1	1	0
Day, Dr. Roberson	..	..	..	..	..	1	1	0
Epps, Dr. ..	..	..	..	..	..	1	1	0
Erskine, Misses ..	..	..	..	..	..	1	1	0
Finlay, Dr. ....	..	..	..	..	..	1	1	0
Goldsbrough, Dr. ...	..	..	..	..	..	2	2	0
Gould, Dr. ...	..	..	..	..	..	1	1	0
Green, Dr. Vincent	..	..	..	..	..	1	1	0
Hawkes, Dr. A. E.	..	..	..	..	..	1	1	0
Hawkes, Dr. E. J.	..	..	..	..	..	2	2	0
Hayle, Dr. ..	..	..	..	..	..	1	1	0
Hayward, Dr. C. W.	..	..	..	..	..	1	1	0
Hayward, Dr. J. ..	..	..	..	..	..	1	1	0
Hey, Dr. Granville	..	..	..	..	..	1	1	0
Hill, Dr. G. Grantham	..	..	..	..	..	1	1	0
Hughes, Dr. Ed. ..	..	..	..	..	..	1	1	0
Johnstone, Dr. ..	..	..	..	..	..	2	2	0
Lambert, Dr. ..	..	..	..	..	..	1	1	0
McLachlan, Dr. ..	..	..	..	..	..	1	1	0
MacNish, Dr. ..	..	..	..	..	..	2	2	0
Madden, Dr. ..	..	..	..	..	..	2	2	0
Miller, Dr. G. ..	..	..	..	..	..	1	1	0
Moir, Dr. Byres ..	..	..	..	..	..	2	2	0
Moore, Dr. Murray	..	..	..	..	..	1	1	0
Murray, Dr. John	..	..	..	..	..	1	1	0
Nankivell, Dr. H.	..	..	..	..	..	2	2	0
Neatby, Dr. E. A.	..	..	..	..	..	2	2	0
Neild, Dr. Edith ..	..	..	..	..	..	1	1	0
Neild, Dr. ..	..	..	..	..	..	2	2	0
Nicholson, Dr. ..	..	..	..	..	..	0	10	6
Norman, Dr. ..	..	..	..	..	..	1	1	0
Ord, Dr. W. T. ..	..	..	..	..	..	1	1	0
Pope, Dr. ..	..	..	..	..	..	2	2	0
Pritchard, Dr. ..	..	..	..	..	..	0	10	6
Pullar, Dr. ..	..	..	..	..	..	1	1	0
Ramsbotham, Dr.	..	..	..	..	..	1	1	0
Renner, Dr. ..	..	..	..	..	..	1	1	0
Roche, Dr. E. B. ...	..	..	..	..	..	2	2	0
Roche, Dr. W. ..	..	..	..	..	..	1	1	0
Sandberg, Dr. ..	..	..	..	..	..	2	2	0
Scriven, Dr. ..	..	..	..	..	..	1	1	0
Searson, Dr. ..	..	..	..	..	..	1	1	0
Shaw, Dr. Frank ..	..	..	..	..	..	1	1	0
Shaw, Mr. Knox ..	..	..	..	..	..	2	2	0
Simpson, Dr. ..	..	..	..	..	..	1	1	0



	£	s.	d.
Stonham, Dr. .. .. .	1	1	0
Süss-Hahnemann, Dr. .. .. .	1	1	0
Tyler, Dr. Margaret .. .. .	1	1	0
Watkins, Dr. .. .. .	1	1	0
Wheeler, Dr. C. .. .. .	1	1	0
Wilde, Dr. Percy.. .. .	1	1	0
Wilmot, Dr. .. .. .	1	1	0
Wilkinson, Mr. C. .. .. .	1	1	0
Wood, Dr. Thorold .. .. .	1	1	0
Wright, Mr. Dudley .. .. .	2	2	0
Wyld, Dr. Geo. .. .. .	2	2	0

## SOCIETY NEWS.

### OFFICERS FOR SESSION 1905-6.

At the Annual Assembly the following officers were elected for the next Session, viz. :—

*President* : Dr. Alfred E. Hawkes, of Liverpool.

*Vice-Presidents* : Dr. Spiers Alexander, Mr. C. J. Wilkinson, of Windsor.

*Treasurer* : Dr. Galley Blackley.

*Council* : The above-named with the following form the Council : (*Ex-President, ex-officio*) Dr. James Johnstone ; (*Fellows*) Dr. Burford, Dr. MacNish, Dr. Byres Moir, Mr. Knox Shaw ; (*Members*) Dr. Neild (Tunbridge Wells), Dr. Stonham.

### OFFICERS FOR 1905-6 (LIVERPOOL BRANCH).

*President* : Dr. Proctor.

*Vice-President* : Dr. James Watson.

*Honorary Secretary and Treasurer* : Dr. James Watson.

*Representative on Council* : Dr. A. E. Hawkes.

### OFFICERS ELECTED BY THE COUNCIL.

At a meeting of the Council held in July the following officers were elected :—

*Honorary Secretary* : Dr. E. A. Neatby.

*Editor* : Dr. Goldsbrough.

*Librarian* : Dr. Lambert.

### SECRETARIES OF SECTIONS.

*Materia Medica and Therapeutics* : Dr. MacNish.

*General Medicine and Pathology* : Dr. Byres Moir.

*Surgery and Gynæcology* : Mr. Knox Shaw.

## SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

*Extracted from Exchange Journals by the Editor, in collaboration with T. G. Stonham, M.D.*

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**Amyl Nitrite as a Hæmostatic.**—In a case of angina pectoris amyl nitrite was given and found to have a marked influence in checking an excessive menstrual flow. This appeared on several occasions in the same patient. The drug was administered by inhalation. This occurrence drew attention to the point and suggested trial of the drug in another severe case of menorrhagia, which it had been found difficult otherwise to relieve. By means of it the loss of blood was kept well within normal limits after other methods had failed, and the patient's condition much improved. The sudden lowering of the blood pressure is without doubt the main factor in checking the hæmorrhage by nitrite of amyl. It allows clotting to take place in the bleeding area, be it ulcerated lung surface or engorged endometrium. The blood pressure rises again, but gradually, and the clots are not displaced. The action of nitrite of amyl appears to be a very close imitation of Nature's method of checking hæmorrhage (*Therapeutic Gazette*, August, p. 542). Is not Nature's method of checking hæmorrhage merely accidental and mechanical, owing to failure of heart and clotting of the blood, the true dynamic energy of Nature consisting of the rise of blood pressure again? Thus nitrite of amyl can never be more than a palliative in cases of hæmorrhage.—ED.

**Appendicitis. Biochemical Treatment.**—Dr. Von der Joly considers that the majority of cases of appendicitis can be brought to a successful issue without surgical treatment by the use of the two remedies, kali-muriaticum and magnesia phosphorica. He gives ferrum phosphoricum in the early stage, but as soon as the case is fully established, and there is exudation, he substitutes kali-muriaticum. The magnesia phosphorica comes in to subdue pain, tympanitis and rigidity of abdominal muscles. In convalescence silica is given to clear away the exudation. (*Homœopathic Recorder*, June, 1905.)—T. G. S.

**Copper.** *Action of the Metal on Organisms in Water.*—The following summary of results of the action of copper on organisms in water is compiled from three articles in the *American Journal of the Medical Sciences* for May, 1905. (1) Copper electrodes carrying a small current are actively germicidal for *Bacillus typhosus* and *B. coli communis*, the former being more easily affected. That it is the copper plays the important rôle is shown by substituting for it platinum electrodes. (2) Dilute solutions of copper destroy many bacteria. The sulphate is most potent. Should copper vessels or plates be used to destroy bacteria in water they must be kept highly polished, or the bactericidal properties will be reduced. (3) There is a natural tendency for typhoidal bacilli to die when water containing them is allowed to stand for a long period. There may be a temporary increase in the number, but this is followed in several hours or days by a final disappearance. Trials were made as to the period of disappearance of *B. typhosus* in sterile water, tap-water, and river surface water, placed in vessels of glass, porcelain, tin, and copper, and their contents kept at room temperature were plated every fifteen minutes for periods ranging from three to six hours. Sterile drinking water in clean copper vessels inoculated with *B. typhosus* showed that the bacilli all perished within one hour. In tin vessels they were living at the end of twenty-four hours. In glass vessels they were living after three hours. In aluminium they had disappeared in three hours. Raw tap-water containing large numbers of river organisms and considerable vegetable matter, when inoculated with millions of typhoid organisms and placed in a copper vessel were killed off in one and three-fourths to two and one-half hours. The quantity of colloidal copper given off from a one-litre copper vessel in three hours was one part to four millions (one-fourth of 3 c.—ED). This amount killed off the added typhoid organisms in from one and three-fourths to two and one-half hours. (*Therapeutic Gazette*, August, p. 542)—ED.

**Formalin.** *Poisoning.*—The following case occurred in Calcutta in April, 1904. W. T., Eurasian, male, 47, when intoxicated swallowed by mistake 3 ounces of a 40 per cent. solution of formalin at 4.30 p.m. He was found by his son groaning, with his right hand over his stomach, and was unable to speak. When able to speak he complained of a burning sensation in the throat and stomach. At 5.30 he was admitted to hospital. On admission he was conscious, answered questions rationally, his pulse was feeble, 140 per minute, pupils equal, rather contracted.

•

Shortly after admission began to vomit, which continued through the night. The stomach had been washed out. The vomited matter consisted of thin sanguineous fluid, and, later, dark-coloured blood and mucus. The pulse became gradually feebler. Death occurred at 10.30 a.m., eighteen hours after ingestion of the poison. Consciousness was retained to the last. The mucous membrane of the stomach was found intensely congested. There were erosions and extravasations of blood. No perforation. The small and large intestines were congested, also the lungs and membranes of the brain. The liver was pale yellow and fatty. This case may be contrasted with another where the patient swallowed several ounces of commercial formalin, and became drowsy and passed into a comatose state. The skin was cold and pale, and his respirations were frequent; there was no paralysis. There was absence of irritant symptoms, but the mucous membranes of the mouth and soft palate were found red and inflamed. The comatose condition was succeeded by cerebral excitement and confusion. There was suppression of urine for several hours. Formalin is probably both narcotic and irritant (*Therapeutic Gazette*, August, p. 536). It is probable alcoholic intoxication prevented narcotism in the first case.—ED.

**Gelsemium.** *A Study.*—Dr. James T. Kent offers the following observations as characteristic in the pathogenesis and therapeutic indications of gelsemium. Gelsemium is a remedy for warm climates. The colds and fevers of the mild winters will be more likely to run to this medicine. In lingering acute troubles, and in those resembling the chronic, it is very useful, but in chronic miasms it is not the remedy. It is a short-acting remedy, although slow in its beginning. The complaints of gelsemium are largely congestive, the symptoms are manifested through the brain and spinal cord. Spasms, coldness of extremities and back, heat and turgescence of face, head, and eyes, mental confusion, incoherence, loss of memory. Pain in the base of the brain and the back of the neck. Considerable fever, with hot skin. In meningitis and fevers calling for gelsemium, the keynote is great weight and tiredness in the entire head, body and limbs. The heart is feeble, the pulse feeble, soft and irregular. Complaints following nervous excitement, with profuse flow of urine. Paralytic affections of the sphincters, with aching in the muscles. Disturbances of ocular muscles, with specks, smoke, or waves of various colours. Sleeplessness followed by profound sleep or coma. Sexual power enfeebled. (*The Clinique*, March, 1905, p. 88.)—ED.

**Stannum Iod. in Phthisis.**—A case is recorded by Drs. G. G. Mack and John B. Garrison, of New York City, where stannum iod. had a marked effect on the progress of a phthisical condition. G. S., negro, 19; occupation, elevator boy. Strong maternal history of phthisis. Took cold at the end of December, 1898. A severe cough followed, < night on lying down, inducing nausea and vomiting, with profuse expectoration of yellow mucus. Physical examination indicates crepitant râles at the apex of the right lung, with slight diminution of resonance. Examination of sputum negative. Drosera was given. His cough was relieved, but in the course of three weeks he had severe night-sweats at 3 a.m., his cough was worse then and accompanied by severe pain in the upper part of the right lung. He received kali carb., first 30 and then 200, and was dieted generously. This treatment was continued until April 15. A few tubercle bacilli had been found on March 15. On April 15 there was noted intense prostration; weakness in the chest; empty feeling after coughing. Sputum sweet and white; shortness of breath; ravenous appetite; right submaxillary gland enlarged; salivation constant. Stannum iod. 6, one dose every two hours, was prescribed. Improvement set in forthwith and continued. On July 1 examination of the sputum was negative. There was absence of râles, but slight dulness persisted. Continued remedy night and morning. This treatment was continued for a year. Frequent examinations of the sputum were made with negative results. In November, 1904, he was apparently well, having continued his occupation, and suffered from a dry hacking cough only when exposed to night air. (*North American Journal of Homœopathy*, July, p. 434.)—ED.

**X-rays. Pathogenesis and Therapeusis.**—In a paper entitled "Can X-rays be Used Homœopathically?" Dr. J. P. Sutherland gives the following summary of the pathogenesis of X-rays: "Erythema, pigmentation, blanching and loosening of the hairs, dermatitis corresponding to the four degrees of heat burns ordinarily described, tingling or burning sensations, desquamation, *vesiculation*. Vesicles may rupture and leave a weeping surface, which is usually rapidly covered by a layer of greyish horny epithelium. In the more severe cases of dermatitis the surface becomes a dark, angry red, and the congestion is intense; *vesicles* and bullæ form, *rupture*, and leave a congested weeping surface. There then develops upon this raw surface a thin yellowish-grey necrotic membrane. Some patients complain very little or not at

all, but in most of them there is very decided *burning and itching*. In some cases the itching is very intense and persistent for a comparatively long time. The skin becomes thinner and atrophied. In burns of the fourth degree the skin becomes brawny and dense; cyanosis; bullæ develop, and these are followed by necrosis of the underlying tissues. The necrotic tissue becomes hard, leathery, dark greyish, mummified. It manifests an almost malignant tendency to persist, in marked contrast with any similar lesion. The injury may extend to the depth of an inch and a half, and it is recorded that the outer table of the skull has been destroyed. *The pain accompanying these lesions is of the most varying intensity. Rarely it is not severe.* In the great majority of cases it is extreme. It is described at times as sharp lancinating pain, again as burning, as if red-hot coals were applied to the part." In cases of continued exposure to X-rays, what has been called precancerous keratosis develops. It is believed that these patches are likely to become epitheliomata, and some of these keratoses, when examined microscopically, have actually shown unmistakable evidences of malignancy, in the form of numerous *mitoses* and *rupture* of epithelium into the corium.

As regards the therapeutics of the X-rays, Dr. Sutherland remarks: "I think I have cured cases of neuralgia, cervical adenitis, eczema, acne, and the dermatitis caused by formaldehyde, and have arrested the growth of cancer, as well as relieved excruciating pain by means of the X-rays." He had personally suffered from a dermatitis of the hands, resulting from the use of formalin solutions. The symptoms were vesiculative itching, soreness and redness of patches of skin of the hands and fingers, rupture of the vesicles, leaving occasionally a raw surface to become covered with a thin yellowish crust. In the last stages the skin had become dry, thin, and cracked, itching and burning are less marked than in the early stages. A few treatments with X-rays put an end to the entire trouble. Dr. Sutherland claims this as an illustration of their homœopathicity to dermatitis. He also offers another case in which this treatment controlled the severe pain of malignant disease in the abdomen over several months, following the use of morphia suppositories, which were subsequently entirely dispensed with. The patient eventually died, and the *post-mortem* record showed disintegration of the malignant mass, so that only one nodule remained, a result Dr. Sutherland also attributed to the electrical treatment. (*North American Journal of Homœopathy*, June, p. 364.)—ED.

**X-rays in Pulmonary Tuberculosis.**—Dr. H. P. Deady, of Liberty, New York, in an interesting paper on “X-rays as Applied to the Diagnosis and Treatment of Pulmonary Tuberculosis,” records the following cases:—

(1) Miss X., aged 24. Came under Dr. Deady's care in October, 1903. At that time a physical examination showed a consolidation affecting practically the entire upper left lobe, with also a small cavity at the third interspace on that side. There was likewise a sympathetic infiltration process at the right apex. The disease was active throughout the upper half of the left lobe, and the process of softening and cavitation was going on at the inner side of the cavity. The larynx became rapidly complicated and ulcerations of the cords with accompanying and complete aphonia ensued. The sputum displayed a mixed infection and elastic tissue was plentiful. A blood analysis gave evidence of a marked leucocytosis, which characteristic usually goes hand in hand with pulmonary cavitation. In spite of the best advantages which the patient was able to fully enjoy, her case lost ground. She lost 10 lbs. in weight, and febrile symptoms increased from an original maximum daily point of  $100^{\circ}$  to  $102^{\circ}$  or more. Gastric symptoms became prominent and the tachycardia more marked. The X-ray treatment was tried as a desperate resort, a 10-inch exposure being given three times weekly. Within one month an improvement was marked. Loss in weight ceased, the cough and expectoration decreased, physical signs indicated a diminution of secretion, and within two months the active fibrosis had set in. Weight increased from 106 to 129 lbs.

(2) Mrs. Y., aged 28, is a young married woman who has been in Liberty for nearly two years. This patient has a simple consolidation at the apex of both lungs, which was more marked on the right side. Her case was chiefly characterised as being what is generally termed “a bleeder.” The blood lost would amount to very little, but there would be rarely a day that the sputum would not be streaked at some time. When actual hæmoptysis did occur it would be but slight, perhaps one or two mouthfuls. For over a year this patient was treated without the slightest benefit. She did not appear to lose ground appreciably, but suffered from anæmia, which caused anxiety if further blood loss could not be averted. The right-sided lesion finally became active, and with a view to reducing this condition X-ray treatment was begun. While somewhat sluggish in response quiescence was finally restored, and hæmorrhage ceased. After two months treatment was stopped, but within ten days hæmoptysis



again appeared, which once more subsided upon reapplication of the treatment.

(3) Mrs. Z., aged 35, residing in Liberty, applied for treatment, August, 1903. A tuberculous infiltration was found at the apex of both lungs. Sputum analysis showed mild mixed infection. The blood count was just under 3,000,000 red corpuscles, and hæmoglobin at 62 per cent. The case had been under excellent hygienic and dietetic treatment, which was continued. A 15-inch and ten-minute exposure was administered three times a week. The subjective symptoms were slight and no material change was noted for fully three months. At that time the cough and expectoration decreased perceptibly. The sputum also cleared, leaving but a simple infection. As improvement continued the exposures were limited to twice weekly. By the fifth month the sputum became negative and only a slight morning cough remained. This patient was kept under observation until early in the summer, and when discharged all physical signs had disappeared, with the exception of a harsh breathing noted at the right apex. The hæmoglobin reached 80 per cent. and red corpuscles 3,800,000. This woman claims to be in excellent general health for the first time since childhood. (*North American Journal of Homœopathy*, August, p. 499.)—ED.



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**OCTOBER, 1905.**

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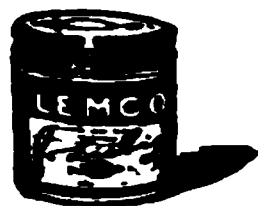
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